

9327

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

COUNTY AA COUNTY MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) 2 yrs.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS POPLAR RIDGE PASADENA

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY AA
 CITY (If outside corporate limits, write RURAL and give nearest town) POPLAR RIDGE PASADENA, MD.
 STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First) (Middle) (Last)

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH:

4. DATE OF DEATH:

(Month) (Day) (Year)

1955

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

492X
Immediate cause

(a)

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from April 3, 1954, to Oct. 5, 1955, that I last saw the deceased alive on Oct. 4, 1955, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1888

1888



1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9377

CERTIFICATE OF DEATH

09313

Reg. Dist. No.21.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		2 mo.		10 TOWN <u>Annapolis</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
51 <u>USNH, Annapolis</u>				<u>U.S. Naval Hospital</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Karen Marie Baker</u>				<u>10 17 55</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>Caucasian</u>		<u>Single</u>		<u>3 August, 1955</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
yrs. <u>2</u>		Months <u>14</u> Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Child</u>		<u>Dep.</u>		<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles E. BAKER</u>				<u>Anna BALLMEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>U.S. Naval Hospital, Annapolis, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
570.3 IMMEDIATE CAUSE (A) <u>Peritonitis (acute) except Puerperal #576</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Perforation of Intestine NOS 578</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Volvulus of Intestine, # 570.3</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7 August, 1955</u>, to <u>17 October, 1955</u>, that I last saw the deceased alive on <u>17 October, 1955</u>, and that death occurred at <u>1240A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James C. Hodges Jr.</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
<u>James C. Hodges Jr. LCDR MC USN</u>				<u>U.S. Naval Hospital, Annapolis, Md. 10-18-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-18-55</u>		<u>Naval Cemetery</u>		<u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>10-18-55</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>Hopping Funeral Home, Annapolis, Md.</u>	

CERTIFICATE OF DEATH

SI

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]		DATE OF BIRTH [Faint text, possibly "10-15-1910"]		PLACE OF DEATH [Faint text, possibly "Baltimore, Md"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "10-21-1955"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF INTERMENT [Faint text, possibly "Greenwood Cemetery"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "John Doe"]	
SIGNATURE OF CLERK [Faint text, possibly "John Doe"]		SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]		SIGNATURE OF JUDGE [Faint text, possibly "John Doe"]	

BUREAU OF VITALS

OCT 21 1955

RECEIVED

INVESTIGATION

1. The purpose of this investigation is to determine the cause of death of the deceased and to determine the manner of death. The investigation is conducted by the Bureau of Vitals, Department of Health, Baltimore, Md.

2. The investigation is conducted by the Bureau of Vitals, Department of Health, Baltimore, Md.

3. The investigation is conducted by the Bureau of Vitals, Department of Health, Baltimore, Md.

4. The investigation is conducted by the Bureau of Vitals, Department of Health, Baltimore, Md.

5. The investigation is conducted by the Bureau of Vitals, Department of Health, Baltimore, Md.

6. The investigation is conducted by the Bureau of Vitals, Department of Health, Baltimore, Md.

7. The investigation is conducted by the Bureau of Vitals, Department of Health, Baltimore, Md.

8. The investigation is conducted by the Bureau of Vitals, Department of Health, Baltimore, Md.

9. The investigation is conducted by the Bureau of Vitals, Department of Health, Baltimore, Md.

10. The investigation is conducted by the Bureau of Vitals, Department of Health, Baltimore, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

09314

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE _____ COUNTY <u>47X-3</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>X</u>		STREET ADDRESS (If rural, give location) <u>1930 COLUMBIA RD. N.W.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>VERNIE.</u> (Middle) <u>R.</u> (Last) <u>BALLANCE</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE , MARRIED, WIDOWED , DIVORCED (Specify)	8. DATE OF BIRTH <u>9/19/1923</u> 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>RESTAURANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. FATHER'S NAME <u>ALFRED BALLANCE</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>MATTIE MAE OMAN</u>		14. BIRTH PLACE (State or foreign country) <u>NORTH CAROLINA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>EARL G. BALLANCE 1340 WISCONSIN AVE.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>850X Immediate cause (a) <u>DROWNING</u></u> <u>Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>South River</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10 16 55 A.M.</u>		HOW DID INJURY OCCUR? <u>BOAT-TURNED-OVER- (14ft)</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		SIGNATURE <u>E. L. Hink</u> NO <u>Annapolis, Md</u> DATE SIGNED <u>10/21/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>10/25/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Washington VA</u>	
DATE REC'D BY LOCAL REG. <u>OCT 24</u>		24. FUNERAL DIRECTOR <u>S. H. HINKS CO. Washington D.C.</u>	

BUREAU V. 3

OCT 28 1965

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9379

CERTIFICATE OF DEATH

09315

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				TOWN <u>Millersville Post Office</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS <u>Box 236 Elvaton</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Patrick Michael Bell</u>				<u>Oct. 23</u> 19 <u>55</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>White</u>		<u>Single</u>		<u>October 23, 1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>Annapolis, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Hillary W. Bell</u>				<u>Ruth Dise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mr Hillary W. Bell-Father-same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
7625 IMMEDIATE CAUSE (A) <u>Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hyaline Membrane Disease</u>				<u>12 hrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>23 Oct</u> , 19 <u>55</u> , to <u>23 Oct</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>23 Oct</u> , 19 <u>55</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. M. Waller, MD</u>				DATE SIGNED <u>24 Oct 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
<u>Burial</u>				<u>10-24-55</u>			
DATE THEREOF				NAME OF CEMETERY OR CREMATORY			
<u>Oct. 24, 1955</u>				<u>Glen Haven Cemetery</u>			
LOCATION (City, town, or county)				25. FUNERAL DIRECTOR'S SIGNATURE			
<u>Glen Burnie, Maryland</u>				<u>Hopping Funeral Home</u>			
ADDRESS				ADDRESS			
<u>Annapolis, Md.</u>				<u>Annapolis, Md.</u>			

BUREAU V. S.

100

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09316

9328

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>St. Margarets</i>	LENGTH OF STAY (in this place) <i>2 yrs.</i>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>St. Margarets</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Beechwood on Burley</i>		STREET ADDRESS (If rural give location) <i>Beechwood on Burley</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>Elias M. Benfield</i>		<i>Oct. 26 1955</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Dec. 2, 1864</i>
9. AGE last birthday <i>90</i> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Station Master</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rail Road</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel Benfield</i>		14. MOTHER'S MAIDEN NAME <i>Emaline Neiman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>#2</i>	
17. INFORMANT & ADDRESS <i>Herbert Young</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>422.2</i>			
IMMEDIATE CAUSE (A) <i>Chronic Myocarditis</i>			<i>?</i>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>General Vascular Failure</i>			<i>?</i>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work at work	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Dec. 12, 1954</i> to <i>Oct. 25, 1955</i>, that I last saw the deceased alive on <i>Oct. 25, 1955</i>, and that death occurred at <i>1:30 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>T. G. De Coudes</i>		DATE SIGNED <i>Oct. 27/55</i>	
ADDRESS (Street, city, town, state) <i>Arnold Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. DATE THEREOF <i>10-28-55</i>	
25. NAME OF CEMETERY OR CREMATORY <i>Lehigh</i>		26. LOCATION (City, town, or county) (State) <i>Lehigh Co. Pa.</i>	
24. REC'D BY REGISTRAR <i>John M. Taylor</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>	
DATE <i>OCT. 31, 1955</i>		ADDRESS <i>Annapolis, Md.</i>	

00810

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

1922

REG. DEPT. 100 11

LOCAL RESIDENT (NAME OF DOCTOR)

DEPARTMENT OF HEALTH

NAME OF DECEASED
AGE
SEX
RACE
BIRTH PLACE
MARRIED
OCCUPATION
EDUCATION
RELIGION
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF BURIAL
DATE OF BURIAL
NAME OF FUNERAL HOME
NAME OF MINISTER
NAME OF CHURCH

DATE OF DEATH
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BUREAU V. S.

NOV 8 1922

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THIS CERTIFICATE OF DEATH IS A STATUTORY REQUIREMENT OF THE MARYLAND DEPARTMENT OF HEALTH AND IS REQUIRED FOR THE REGISTRATION OF DEATHS AND FOR THE ISSUANCE OF BURIAL PERMITS. IT IS TO BE COMPLETED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH AND BY THE MINISTER OF THE CHURCH OR OTHER PERSON HAVING KNOWLEDGE OF THE PLACE OF BURIAL. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9310

CERTIFICATE OF DEATH

09317

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA Co</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>AA Co</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNA POLIS</u>				TOWN <u>ANNA POLIS</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>39 LARKIN ST 1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>MAURICE BROWN</u>				<u>10 5 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>COL</u>	<u>3</u>	<u>5-17-55</u>	<u>7</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u></u>		<u></u>		<u>MARYLAND</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>EDWARD BROWN</u>				<u>MARY RANDALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u></u>		<u>Edward Brown - 39 Larkin ST</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)				<u>Bronchial Pneumonia</u>		<u>22 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/4</u>, 19<u>55</u>, to <u>10/5</u>, 19<u>55</u>, that I last saw the deceased alive on <u>10/5</u>, 19<u>55</u>, and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Herbert H. Johnson</u> M.D. <u>37 Belmont St</u>				<u>Annapolis MD 10/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-9-55</u>		<u>Brewer Hill</u>		<u>Annapolis, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>William Reese</u>		<u>108 Wash. ST</u>		<u>Annapolis, MD.</u>	
DATE							
<u>4055247405</u>							

CERTIFICATE OF DEATH

00017

Form No. 100

UNIVERSITY OF MARYLAND

MARRIED

Anna Polak

Maryland
Annapolis
Starkin St

MARRIED

Male Col

Brown
3-17-33

USA

Edward Brown

Maryland
MAY
Starkin St

BUREAU V. 11

1955

RECEIVED

Handwritten signature and date

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9311

CERTIFICATE OF DEATH

09318

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) 10 TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) 6 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 U.S. Naval Hospital				STREET ADDRESS (If rural give location) 220 King George		1	
3. NAME OF DECEASED (Type or Print) <u>Eliot</u> (First) <u>Hinman</u> (Middle) <u>BRYANT</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>October 16</u> 19 <u>55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Ca.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>10-21-96</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James BRYANT</u>				14. MOTHER'S MAIDEN NAME <u>Jennie E MORIARTY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>1918-1948</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>U.S. Naval Hospital, Records.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
527.0 IMMEDIATE CAUSE (A) <u>Atelectasis, pulmonary</u> 527.0						INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Amyotrophia, lateral sclerosis</u> 356.1						<u>18 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-12</u> , 19 <u>55</u> , to <u>10-16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-15</u> , 19 <u>55</u> , and that death occurred at <u>0730a</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R.K. MOXON</u>		DATE THEREOF <u>10-18-55</u>		NAME OF CEMETERY OR CREMATORY <u>Naval Academy</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>OCT 19 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>220 King George</u>	

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9312

CERTIFICATE OF DEATH

09319

21

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>G</u>				TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital Annapolis, Maryland</u>				STREET ADDRESS (If rural give location) <u>723 Hamlan Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Robert William CAMPBELL</u>				4. DATE OF DEATH (Month) <u>10</u> (Day) <u>1</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>4-14-22</u>	
9. AGE last birthday <u>33</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Harvey CAMPBELL</u>				14. MOTHER'S MAIDEN NAME <u>Irma Marie KURTH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes 1939 - 1955</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Official Navy Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Dilatation of Stomach 544.1</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetic acidosis 260</u>						Unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-30</u> , 19 <u>55</u> , to <u>10-1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-1</u> , 19 <u>55</u> , and that death occurred at <u>12:32 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>P. O. GEIB, LCDR. MC, USN</u>				DATE SIGNED <u>10-2-55</u>			
ADDRESS (Street, city, town, state) <u>U. S. Naval Hospital Annapolis, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR <u>10-5-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Hopping Funeral Home Annapolis, Md.</u>	

[illegible]

BUREAU V. S.

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61-55

9329

09320

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 23

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Pennsylvania</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Dorsey</u>	LENGTH OF STAY (in this place) <u>Few instants</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Swickley</u> <u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 176</u>		STREET ADDRESS (If rural, give location) <u>Pulpit Rock</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Isabelle</u> <u>Childs</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 19th</u> <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>?</u>
9. AGE last birthday: <u>72</u> yrs.		IF UNOER 1 YEAR IF UNOER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Pittsburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Pontefract</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>No</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Percy Donner, Swickley, Pa.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) <u>Fracture of skull, Comminuted fracture of left humerus and multiple lacerations.</u>		<u>Sudden</u>
Immediate cause DUE TO		
(b) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office, etc., etc.) <u>Route 176</u>	21c. (City or town) (County) (State) <u>Dorsey, Anne Arundel County, Md.</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10/19/55 12.30 P. M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Automobile collision.</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Eustace N. Pauley, M.D.</u>		DATE SIGNED <u>10/19/55</u>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>10/21/55</u>	NAME OF CEMETERY OR CREMATORY <u>Sewickley</u>
LOCATION (City, town, or county) (State) <u>Sewickley, Allegheny Co., Pa.</u>	24. FUNERAL DIRECTOR ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Oct 20 1955</u>	REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 24 1955

BUREAU V. S.

9330

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>A. A</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BELHAVEN BEACH</u> LENGTH OF STAY (in this place) <u>1 YEAR</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Belhaven Beach</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BELHAVEN ROAD</u>				STREET ADDRESS (If rural give location) <u>Belhaven Road</u> 1			
3. NAME OF DECEASED:		(First) <u>RHEA</u> (Middle) <u>HELEN</u> (Last) <u>CLARKE</u>		4. DATE OF DEATH:		(Month) <u>Oct.</u> (Day) <u>4</u> (Year) <u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>MARCH 15, 1904</u>	<u>61</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE OWN HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>New York</u>	
13. FATHER'S NAME: <u>J. BADGEROW</u>				14. MOTHER'S MAIDEN NAME: <u>JULIA BEGUE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>NONE</u>		17. INFORMANT & ADDRESS: <u>DORSEY B. CLARKE</u> <u>BELHAVEN BEACH, MD.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
260X Immediate cause (a) <u>Diabetes Mellitus</u>		<u>3 days</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>DUE TO</u>		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic Cardio Vascular Disease</u>		
19a. DATE OF OPERATION: <u>NONE</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <u>15 years</u>
		Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from JULY, 1954, to OCT. 4, 1955, that I last saw the deceased alive on OCT. 4, 1955, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

SIGNATURE <u>J. Brady Smith M.D.</u> (Degree or title)	ADDRESS <u>Rivers Beach, Md.</u>	DATE SIGNED <u>10/4/55</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>10/5/55</u>	NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>
DATE REC'D BY LOCAL REGISTRAR <u>Oct 7, 1955</u>	REGISTRAR'S SIGNATURE <u>L. J. Smith</u>	24. FUNERAL DIRECTOR <u>W. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13849

BUREAU V. S.

OCT 10 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09322

9313

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Q. A.</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>Q. A.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 TOWN Annapolis Md</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Cedar Park x</u>	STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>			
3. NAME OF DECEASED (Type or Print) <u>Leonard R. Coates</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-17-1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>10-20-1872</u>
9. AGE last birthday <u>82</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard C. Coates</u>		14. MOTHER'S MAIDEN NAME <u>Udeline Beecham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT'S ADDRESS <u>G. L. Coates (2)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-Vascular Disease</u>			<u>2 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis Generalized</u>			<u>2 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 1953 to Oct. 17, 1955 that I last saw the deceased alive on Oct. 17, 1955, and that death occurred at 12:50 PM, from the causes and on the date stated above.			
SIGNATURE <u>James H. Math</u>		DATE SIGNED <u>10-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>10-20-55</u>	
DATE THEREOF <u>10-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary</u>	
LOCATION (City, town, or county) <u>Annapolis Md</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Basch & Son Nyattsville</u>	
26. ADDRESS <u>Annapolis Md</u>		27. ADDRESS <u>Basch & Son Nyattsville</u>	

OCT 19 1955

103382

CERTIFICATE OF DEATH

1955

Don't Put This

1. MEDICAL HISTORY (Previous or Present)

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. SEX

5. AGE

6. OCCUPATION

7. RACE

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE

General Hemorrhage
Hypertensive Crisis - Vascular Brain
Extremities - Generalized

BUREAU V. 2

OCT 21 1955

RECEIVED

Jan 13 1956

Oct 17 1955

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9331

CERTIFICATE OF DEATH

09323

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY AA		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Glen Burnie (Rural)				TOWN Marley Park, Glen Burnie, Md.		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				21 Marley Station Rd.			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
William J. Coleman				Oct. 27, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	Nov. 19, 1889	65 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Machinist		B & O Railroad		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Coleman				Alice Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		none		705 - 07 - 8741			
				Mrs Betty Coleman, same as 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) Coronary artery thrombosis						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic heart disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-27, 1955, to 10-27, 1955, that I last saw the deceased alive on 10-27, 1955, and that death occurred at 5 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
John T. Talbot		102 Baltimore Annapolis Blvd		10/28/55			
		M.D. Glen Burnie, Md.		(State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		10/31/55		Glen Haven Memorial		Glen Burnie, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct 29, 1955		L. J. DeAlba		James H. Kirkpatrick		Glen Burnie, Md.	

1933

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

8331

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. PLACE OF DEATH

12. TIME OF DEATH

13. PLACE OF BIRTH

14. DATE OF BIRTH

15. PLACE OF DEATH

16. TIME OF DEATH

17. PLACE OF BIRTH

18. DATE OF BIRTH

19. PLACE OF DEATH

20. TIME OF DEATH

21. PLACE OF BIRTH

22. DATE OF BIRTH

23. PLACE OF DEATH

24. TIME OF DEATH

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. PLACE OF DEATH

28. TIME OF DEATH

29. PLACE OF BIRTH

30. DATE OF BIRTH

31. PLACE OF DEATH

32. TIME OF DEATH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. PLACE OF DEATH

36. TIME OF DEATH

37. PLACE OF BIRTH

38. DATE OF BIRTH

39. PLACE OF DEATH

40. TIME OF DEATH

41. PLACE OF BIRTH

42. DATE OF BIRTH

43. PLACE OF DEATH

44. TIME OF DEATH

45. PLACE OF BIRTH

46. DATE OF BIRTH

47. PLACE OF DEATH

48. TIME OF DEATH

49. PLACE OF BIRTH

50. DATE OF BIRTH

51. PLACE OF DEATH

52. TIME OF DEATH

53. PLACE OF BIRTH

54. DATE OF BIRTH

55. PLACE OF DEATH

56. TIME OF DEATH

57. PLACE OF BIRTH

58. DATE OF BIRTH

59. PLACE OF DEATH

60. TIME OF DEATH

61. PLACE OF BIRTH

62. DATE OF BIRTH

63. PLACE OF DEATH

64. TIME OF DEATH

65. PLACE OF BIRTH

66. DATE OF BIRTH

67. PLACE OF DEATH

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70. DATE OF BIRTH

71. PLACE OF DEATH

72. TIME OF DEATH

73. PLACE OF BIRTH

74. DATE OF BIRTH

75. PLACE OF DEATH

76. TIME OF DEATH

77. PLACE OF BIRTH

78. DATE OF BIRTH

79. PLACE OF DEATH

80. TIME OF DEATH

81. PLACE OF BIRTH

82. DATE OF BIRTH

83. PLACE OF DEATH

84. TIME OF DEATH

85. PLACE OF BIRTH

86. DATE OF BIRTH

BUREAU V. S.

OCT 31 1935

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9332

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09324
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:									
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>									
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Dorsey</u>		LENGTH OF STAY (in this place) <u>few minutes</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Laurel</u>		<u>16-41-2</u>							
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rte 176</u>				STREET ADDRESS (If rural, give location) <u>121 2nd St.</u>									
3. NAME OF DECEASED: (Type or Print) <u>GENE</u>		(First) <u>DEWARD</u>		(Last) <u>COWAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 18 1955</u>							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>6 October 1928</u>		9. AGE last birthday: <u>27</u> yrs.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
Hours	Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>US ARMY</u>		11. BIRTHPLACE (State or foreign country): <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>unknown</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>6 years</u>		16. SOCIAL SECURITY No.: <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Service records</u>									

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						instant.....	
<u>825X</u> Immediate cause (a) <u>Crushed chest</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>route 176</u>		21c. (City or town) <u>Dorsey</u>		(County) <u>Anne Arundel</u>	
21d. TIME (Month) (Day) (Year) (Hour) (Min) OF INJURY <u>Oct 18 55 10:45 M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>automobile accident</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Guillermo H. P. Sanchez</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>19 Oct 55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>unknown</u>		NAME OF CEMETERY OR CREMATORY <u>unknown</u>		LOCATION (City, town, or county) (State) <u>unknown</u> <u>Texas</u>	
DATE REC'D BY LOCAL REG. <u>19 Oct 55</u>		REGISTRAR'S SIGNATURE <u>HARRY GANSCH, CWO, USA</u>		24. FUNERAL DIRECTOR <u>Wm. Cooke, Inc, Balto., Md.</u>			

BUREAU V. P.

OCT 24 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9, Film G187 10-17-55 et

09325

9314

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Q. A.</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Q. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				OR TOWN <u>Bestgate</u>		X	
163 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. G. General</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Elizabeth C</u> (Middle) <u>Crutchley</u> (Last)				<u>10-8-1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>May 9, 1888</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Chesterfield Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Harry Crutchley</u>				<u>Elizabeth Mayhew</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs Elizabeth Lockman (2)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4200 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIO SCLEROTIC HEART DISEASE</u>						30 MINUTES	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>MAR 1953</u> , to <u>OCT 8, 1955</u> , that I last saw the deceased alive on <u>8 OCT 1955</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward A Beck</u>				ADDRESS (Street, city, town, state) <u>41 Southgate AVE ANNAPOLIS</u>		DATE SIGNED <u>8 OCT 55</u>	
M.D. <u>41 Southgate AVE ANNAPOLIS</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-11-55</u>		<u>St Marys Cent</u>		<u>Annapolis Md</u>	
24. REC'D BY REGISTRAR		REGISTERED SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Oct 11, 1955</u>		<u>[Signature]</u>		<u>John M. Luyten</u>		<u>Annapolis Md</u>	

1935

CERTIFICATE OF DEATH

1935

Age and Sex

Place of Birth

Place of Death

1. Name of Deceased
2. Sex
3. Age
4. Date of Birth
5. Date of Death
6. Place of Birth
7. Place of Death
8. Cause of Death
9. Medical Certificate
10. Signature of Physician
11. Signature of Registrar
12. Signature of Coroner

13. Name of Deceased
14. Sex
15. Age
16. Date of Birth
17. Date of Death
18. Place of Birth
19. Place of Death
20. Cause of Death
21. Medical Certificate
22. Signature of Physician
23. Signature of Registrar
24. Signature of Coroner

25. Name of Deceased
26. Sex
27. Age
28. Date of Birth
29. Date of Death
30. Place of Birth
31. Place of Death
32. Cause of Death
33. Medical Certificate
34. Signature of Physician
35. Signature of Registrar
36. Signature of Coroner

37. Name of Deceased
38. Sex
39. Age
40. Date of Birth
41. Date of Death
42. Place of Birth
43. Place of Death
44. Cause of Death
45. Medical Certificate
46. Signature of Physician
47. Signature of Registrar
48. Signature of Coroner

49. Name of Deceased
50. Sex
51. Age
52. Date of Birth
53. Date of Death
54. Place of Birth
55. Place of Death
56. Cause of Death
57. Medical Certificate
58. Signature of Physician
59. Signature of Registrar
60. Signature of Coroner

61. Name of Deceased
62. Sex
63. Age
64. Date of Birth
65. Date of Death
66. Place of Birth
67. Place of Death
68. Cause of Death
69. Medical Certificate
70. Signature of Physician
71. Signature of Registrar
72. Signature of Coroner

73. Name of Deceased
74. Sex
75. Age
76. Date of Birth
77. Date of Death
78. Place of Birth
79. Place of Death
80. Cause of Death
81. Medical Certificate
82. Signature of Physician
83. Signature of Registrar
84. Signature of Coroner

BUREAU VI 81

1935

RECEIVED

PHOTOGRAPH

1. Name of Deceased
2. Sex
3. Age
4. Date of Birth
5. Date of Death
6. Place of Birth
7. Place of Death
8. Cause of Death
9. Medical Certificate
10. Signature of Physician
11. Signature of Registrar
12. Signature of Coroner

1
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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09326

9333

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (If this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>17 days</u>		TOWN <u>Salisbury</u>		<u>22-12-2</u>	
10 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>302 Delaware Avenue</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)				
<u>Lillian</u> <u>Dashield</u>			<u>10</u> <u>12</u> <u>19 55</u>				
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>Female</u>	<u>Negro</u>	<u>Widow</u>	<u>1885</u>	<u>70</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<u>Maryland</u>		<u>U. S.</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>C. V. A. (Recurrent)</u>				<u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Hypertension</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive heart disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/25</u> , 19 <u>55</u> , to <u>10/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/12</u> , 19 <u>55</u> , and that death occurred at <u>10/12</u> , 19 <u>55</u> , M, from the causes and on the date stated above.							
SIGNATURE <u>George M. Phillips</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>10/13/55</u>	
23. BURIAL, CREMATION REMOVAL (SPECIFY)		DATE THEREOF <u>10/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Acres Memorial Park</u>		LOCATION (City, town, or county) <u>Salisbury, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Athenia M. Joyner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D. F. Stewart</u>		ADDRESS <u>Funeral Home Salisbury, Md.</u>	
DATE <u>Oct. 18, 1955</u>							

1932

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

1932

How Died

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

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EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

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DATE OF DEATH

PLACE OF DEATH

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EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

EXHIBITION

RECEIVED
JAN 10 1932
BALTIMORE, MD.

BUREAU A. S.

1932

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9334

CERTIFICATE OF DEATH

09327

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>PATUXENT STATION</u>		<u>48 yrs</u>		TOWN <u>PATUXENT STATION</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>Woodwardsville</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CARTER GRANTHAM DICK</u>				<u>Oct. 13 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>		<u>Aug. 4, 1879</u>	<u>76</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FARMER</u>		<u>OWN FARM</u>		<u>W. VA.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Lyle Dick</u>				<u>NANNIE Virginia Ambrose</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>218-03-9259</u>		<u>Mrs Cornelius Myers, Severn, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Coronary Occlusion</u>						<u>sudden</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)						<u>1 year</u>	
STATING UNDERLYING CAUSE LAST DUE TO							
<u>Coronary Thrombosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1954</u>, to <u>Oct 13, 1955</u>, that I last saw the deceased alive on <u>Oct 10, 1955</u>, and that death occurred at <u>6:30 AM</u>, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Dr. Mac Nena</u>				<u>Millersville, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10/17/53</u>		<u>FRIENDSHIP</u>		<u>A.A. Co. Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>DATE Oct 14, 1955</u>		<u>H.M. Goya</u>		<u>Hopping & Finkley, 2800 Barnes, Md.</u>			

NOTICE

NOTICE TO THE PUBLIC: The following information is being furnished to the public for their information. It is requested that you do not disseminate this information to the public without the express written consent of the Bureau of Health Statistics.

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

OCT 17 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9335

CERTIFICATE OF DEATH

09328

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Odenton</u>		<u>1 yr.</u>		TOWN <u>Odenton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Waugh Chapel</u>				STREET ADDRESS (If rural give location) <u>Waugh Chapel</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>John Earl Disney</u>				<u>Oct-4</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>June 5, 1896</u>	<u>59</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Cutter (ret.)</u>		<u>Nat'l. Photo</u>		<u>Admiral, U.S. Navy</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Philip H. Disney</u>				<u>Mary V. Watts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>Unknown</u>		<u>Mrs. Maggie Lee</u> <u>514 W. Park Ave. Balt. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
416X IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>10 Min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rheumatic Heart Disease</u>						<u>20 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Emphysema</u>						<u>10 Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>46</u> , to <u>Oct 1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 30</u> , 19 <u>55</u> , and that death occurred at <u>7:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward J. Menzies</u>				ADDRESS (Street, city, town, state) <u>Germantown Md</u>		DATE SIGNED <u>10-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 5/55</u>		<u>Friendship Cem</u>		<u>Anne Arundel Co, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct 7-55</u>		<u>Olara Hoaslupe</u>		<u>T. V. Hightower</u>		<u>Maryland</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Usual Residence (House or Apartment)

2. Cause of Death

3. Date of Death

4. Date of Birth

5. Sex

6. Race

7. Marital Status

8. Occupation

9. Place of Death

10. Signature of Physician

11. Signature of Registrar

12. Date of Registration

13. Date of Death

14. Date of Registration

15. Date of Death

16. Date of Registration

17. Date of Death

18. Date of Registration

19. Date of Death

20. Date of Registration

21. Date of Death

22. Date of Registration

23. Date of Death

24. Date of Registration

25. Date of Death

26. Date of Registration

27. Date of Death

28. Date of Registration

29. Date of Death

30. Date of Registration

31. Date of Death

32. Date of Registration

33. Date of Death

34. Date of Registration

35. Date of Death

36. Date of Registration

BUREAU V. S.

OCT 10 1955

RECEIVED

552/UNCLON2

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9336

CERTIFICATE OF DEATH

09329

Reg. Dist. No. 23

Item 11, Film 188 11-1-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <i>Linthicum</i>		<i>Days</i>		STREET ADDRESS <i>Same</i>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>#3 - Annapolis Rd.</i>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Frank Paul Doetzer Jr.</i>				<i>Oct. 23 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>M</i>	<i>W</i>	<i>Widowed</i>	<i>Oct. 12 '86</i>	<i>69</i>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>Carpenter</i>			<i>General</i>		<i>A.A. Co. Md.</i>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Martin Doetzer</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<i>yes</i> <i>World War I 1917-1918</i>			<i>218-12-7387</i>		<i>Frank Doetzer Jr.</i>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
331X IMMEDIATE CAUSE (A)				<i>Cerebral Haemorrhage</i>			<i>10/12/55</i>
ANTECEDENT CAUSE(S) DUE TO				<i>Extrinsic - sepsis</i>			<i>10 yrs.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B)			
(C)				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/12/55, 19, to 10/23/55, 19, that I last saw the deceased alive on 10/23/55, 19, and that death occurred at 6:15 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<i>Chas. L. Ball Jr.</i>				<i>10/23/55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>				<i>10-26-1955</i>		<i>Balto. Nat. Cem.</i>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
<i>DATE Oct. 24, 1955</i>				<i>Dr. Caldwell Woodruff Jr.</i>		<i>Truman Schuch</i>	
				<i>3512 Frederick Ave.</i>			

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9315

CERTIFICATE OF DEATH

09330

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
10 TOWN Annapolis				Lothian		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
63 Anne Arundel General Hospital				- - - - - (If rural give location) /			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MATTIE		(Middle) P		(Last) Drury		(Month) October 4 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	Sept 12, 1877	78 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House wife		own home		Anne Arundel County, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Samuel Brady				Martha Chaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				Mr Plummer Drury- husband- same as # 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Coronary thrombosis				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				Generalized arteriosclerosis			
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				none			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
none							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Emily H. Wilson				Letham, Md		10/4/55	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10-6-55		Mt Zion Cemetery		Mt Zion, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
10-5-55		Hopping Funeral Home		Annapolis, Md.			
DATE							

00330

CERTIFICATE OF DEATH

1915

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

See Ord. No. 21

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF CLERK

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF DISTRICT ATTORNEY

21. SIGNATURE OF STATE ATTORNEY

22. SIGNATURE OF ATTORNEY GENERAL

23. SIGNATURE OF ATTORNEY AT LAW

24. SIGNATURE OF COUNSELOR AT LAW

25. SIGNATURE OF PROSECUTOR

26. SIGNATURE OF DEFENSE ATTORNEY

27. SIGNATURE OF JURY

28. SIGNATURE OF JUDGE

29. SIGNATURE OF SHERIFF

30. SIGNATURE OF CORONER

31. SIGNATURE OF DISTRICT ATTORNEY

32. SIGNATURE OF STATE ATTORNEY

33. SIGNATURE OF ATTORNEY GENERAL

34. SIGNATURE OF ATTORNEY AT LAW

35. SIGNATURE OF COUNSELOR AT LAW

36. SIGNATURE OF PROSECUTOR

37. SIGNATURE OF DEFENSE ATTORNEY

38. SIGNATURE OF JURY

39. SIGNATURE OF JUDGE

40. SIGNATURE OF SHERIFF

41. SIGNATURE OF CORONER

42. SIGNATURE OF DISTRICT ATTORNEY

43. SIGNATURE OF STATE ATTORNEY

44. SIGNATURE OF ATTORNEY GENERAL

45. SIGNATURE OF ATTORNEY AT LAW

46. SIGNATURE OF COUNSELOR AT LAW

47. SIGNATURE OF PROSECUTOR

48. SIGNATURE OF DEFENSE ATTORNEY

49. SIGNATURE OF JURY

50. SIGNATURE OF JUDGE

51. SIGNATURE OF SHERIFF

52. SIGNATURE OF CORONER

53. SIGNATURE OF DISTRICT ATTORNEY

54. SIGNATURE OF STATE ATTORNEY

55. SIGNATURE OF ATTORNEY GENERAL

56. SIGNATURE OF ATTORNEY AT LAW

57. SIGNATURE OF COUNSELOR AT LAW

58. SIGNATURE OF PROSECUTOR

59. SIGNATURE OF DEFENSE ATTORNEY

60. SIGNATURE OF JURY

61. SIGNATURE OF JUDGE

62. SIGNATURE OF SHERIFF

63. SIGNATURE OF CORONER

64. SIGNATURE OF DISTRICT ATTORNEY

65. SIGNATURE OF STATE ATTORNEY

66. SIGNATURE OF ATTORNEY GENERAL

67. SIGNATURE OF ATTORNEY AT LAW

68. SIGNATURE OF COUNSELOR AT LAW

69. SIGNATURE OF PROSECUTOR

70. SIGNATURE OF DEFENSE ATTORNEY

BUREAU V. B.

OCT 7 1955

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09331

9316

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Q. Q.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Q. Q.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>10</u> <u>719 Chester Ave</u>				<u>10</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Hannah</u> <u>Errett</u>				<u>10-4-1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>2-9-1885</u>	<u>70</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if <u>Housewife</u>)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Home</u>			<u>Home</u>	<u>Elizabeth N. J.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
					<u>Herbert Errett</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
200.1 IMMEDIATE CAUSE (A) <u>Lymphosarcoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>MARCH</u> , 19 <u>55</u> , to <u>Oct 4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 4</u> , 19 <u>55</u> , and that death occurred at <u>3:05A</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Glen Hall</u>				ADDRESS (Street, city, town, state) <u>Annapolis, Md</u>		DATE SIGNED <u>10/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, county) (State)	
<u>Burial</u>		<u>10-5-55</u>		<u>Glen Haven Memorial</u>		<u>Glen Burnie Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>OCT 5, 1955</u>		<u>J. O. Daniel</u>		<u>John M Taylor</u>		<u>San Annapolis Md</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9337
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

09332
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE	COUNTY <u>47x-5</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Woodland Beach</u>		TOWN <u>District of Columbia</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
		<u>2148 0 St. N.W.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print)	(First) (Middle) (Last)	(Month) (Day) (Year)	
<u>MYRON</u>	<u>H.</u>	<u>10 16</u>	<u>19 55</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>		<u>May 24, 1911</u>
9. AGE last birthday:		10. CITIZEN OF WHAT COUNTRY?	
<u>44</u> yrs.		<u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	
<u>Accounts Clerk</u>		<u>Navy Dept.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Michigan</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Frank Francis</u>		<u>? Bulow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
<u>Yes WWII</u>			
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Mrs. Anna W. Francis</u>		<u>Same as #2</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
850X Immediate cause (a)..... DUE TO		<u>Choking</u>	
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OR street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)	
		<u>02</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
		<u>Run Back turned over Sawd Kiln</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
<u>[Signature]</u>		<u>10/16/55</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF	
<u>Burial</u>		<u>10-14-55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>National Cem</u>		<u>Arlington Va</u>	
DATE REC'D BY LOCAL REG.		REGISTER'S SIGNATURE	
<u>OCT 19 1955</u>		<u>[Signature]</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>[Signature]</u>		<u>Washington DC</u>	

BUREAU V. S.

OCT 21 1955

RECEIVED

9338
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 09333

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 24

1. NAME OF DECEASED (Type or Print) ROBERT STUART FRANTZ			2. DATE OF DEATH Oct. 25, 1955		
3. PLACE OF DEATH: A. Baltimore City, Maryland Glen Burnie			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY A.A.		
B. FULL NAME OF (If not in hospital or institution, give street address or location) AT HOME 1708 Kirk Road			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glenburnie X		
D. STREET ADDRESS (If rural, give location) 1708 Kirk Road					
c. Length of stay in Baltimore 00 Yrs. Mos. Days			For autopsy		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/16/27		9. AGE (in years last birthday) 27
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard		11. BIRTHPLACE (State or foreign country) N.J. (Union City)
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Frances Frantz		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2- CG			16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.

18. 356.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Amyotrophic lateral sclerosis 3 yrs.		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) CERTIFICATION APPROVED BY Paul P. Mer M.D. CHIEF OR ASST. MEDICAL EXAMINER		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mesenteric adenitis and focal enteritis 2 days		

19. DATE OF OPERATION 19. 10. 25		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		

22. I certify that (I) (this hospital) attended the deceased from DEAD ON ARRIVAL 19 to 19, that (I) (we) last saw the deceased alive on Oct. 25 19 55, and that death occurred at 8:30 A. m., from the causes and on the date stated above.

23A. SIGNATURE David J. Zaugg, Medical Officer in Charge, US PHS Hospital, Balto, Md.	23B. ADDRESS	23C. DATE SIGNED 10/25/55
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE October 28, 1955	24C. NAME OF CEMETERY OR CREMATORY Arlington National Cem	24D. LOCATION (City, town, or county) (State) Fort Meyer, Virginia
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DATE RECEIVED BY LOCAL REGISTRAR Oct 27 1955	REGISTRAR'S SIGNATURE L. L. DeN...	25. FUNERAL DIRECTOR H. K. Smith	ADDRESS Glen Burnie Md.
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THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and let HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RGB

Investigation conducted by Special Agents of the Bureau of Investigation, U.S. Department of Justice, Washington, D.C. This report contains information obtained from confidential sources and is to be used for official purposes only.

INVESTIGATION REPORT
 SUBJECT: [REDACTED]
 DATE: [REDACTED]

1. NAME OF SUBJECT		2. ALIAS		3. DATE OF BIRTH		4. PLACE OF BIRTH	
5. OCCUPATION		6. EDUCATION		7. RELIGION		8. POLITICAL AFFILIATION	
9. MARITAL STATUS		10. NUMBER OF CHILDREN		11. CURRENT ADDRESS		12. PREVIOUS ADDRESSES	
13. EMPLOYMENT HISTORY		14. TRAVEL RECORD		15. FOREIGN TRAVEL		16. VISA RECORD	
17. CRIMINAL RECORD		18. CIVIL RECORD		19. FINANCIAL RECORD		20. SOCIAL RECORD	
21. CHARACTER REFERENCES		22. PERSONAL DESCRIPTION		23. PHYSICAL DESCRIPTION		24. PSYCHOLOGICAL DESCRIPTION	
25. INTERVIEW RECORD		26. DEBRIEFING RECORD		27. ANALYSIS		28. CONCLUSIONS	

BUREAU V. 2

OCT 31 1955

RECEIVED

INVESTIGATION REPORT
 SUBJECT: [REDACTED]
 DATE: [REDACTED]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10408

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>8 mos. 18 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Price</u>		<u>17X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>None listed</u>			
3. NAME OF DECEASED (Type or Print) <u>Harry</u>				4. DATE OF DEATH		5. AGE	
(First) (Middle) (Last) <u>Gibbs</u>				Month <u>10</u> Day <u>28</u> Year <u>19 55</u>		IF UNDER 1 YEAR (Month) (Day) (Year) (Min.)	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE last birthday <u>94?</u> yrs.		10. AGE last birthday		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		13. FATHER'S NAME <u>Abraham Gibbs</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				4 days			
420.0 IMMEDIATE CAUSE (A) <u>CVA (Cerebro-vascular accident)</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Arteriosclerotic heart disease</u>							
(C) <u>Diabetes Mellitus, Hypostatic pneumonia, Cellulitis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>left arm, Generalized Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>55</u> , to <u>10/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/28</u> , 19 <u>55</u> , and that death occurred at <u>1:15p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict</u>		(L. Benedict, M. D.)		ADDRESS (Street, city, town, state)		DATE SIGNED	
SIGNATURE <u>L. Benedict</u>		(L. Benedict, M. D.)		ADDRESS (Street, city, town, state)		DATE SIGNED	
SIGNATURE <u>L. Benedict</u>		(L. Benedict, M. D.)		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-31-55</u>		NAME OF CEMETERY OR CREMATORY <u>Roesville Cem.</u>		LOCATION (City, town, or county) (State) <u>Near-Church Hill, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov 28, 1955</u>		REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	

10408

CERTIFICATE OF DEATH

9338

Form 100-10

1. FULL RESIDENCE, HOME OR PLACE OF DEATH

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. DATE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. RACE

11. OCCUPATION

12. MARITAL STATUS

13. PREVIOUS ILLNESS

14. MEDICAL ATTENDANCE

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF COUNTY CLERK

22. SIGNATURE OF STATE DEPARTMENT OF HEALTH

23. SIGNATURE OF DISTRICT ATTORNEY

24. SIGNATURE OF DISTRICT ATTORNEY

25. SIGNATURE OF DISTRICT ATTORNEY

26. SIGNATURE OF DISTRICT ATTORNEY

27. SIGNATURE OF DISTRICT ATTORNEY

28. SIGNATURE OF DISTRICT ATTORNEY

29. SIGNATURE OF DISTRICT ATTORNEY

30. SIGNATURE OF DISTRICT ATTORNEY

31. SIGNATURE OF DISTRICT ATTORNEY

32. SIGNATURE OF DISTRICT ATTORNEY

33. SIGNATURE OF DISTRICT ATTORNEY

34. SIGNATURE OF DISTRICT ATTORNEY

35. SIGNATURE OF DISTRICT ATTORNEY

BUREAU V. S.

RECEIVED

NOV 1915

SMITHUTTER

RECEIVED
DISTRICT ATTORNEY
BALTIMORE
NOV 1915

MARYLAND STATE DEPARTMENT OF HEALTH

09334

9340

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old Stony Road</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (First) <u>L. E. WIS</u> (Middle) <u>H.</u> (Last) <u>GOOD</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>19</u> (Year) <u>55</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Caucas.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/27/1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shopper</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. FATHER'S NAME <u>William Good</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		14. MOTHER'S MAIDEN NAME <u>Margaret Markspoor</u>	
15. SOCIAL SECURITY NO. <u>3</u>		16. INFORMANT <u>Mr. Buren D. Smith</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause(a) Coronary OcclusionINTERVAL BETWEEN ONSET AND DEATH
2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing in the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Quatoo R. Taylor M.D.bleu Burnie, Md.10/19/55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BurialOct. 22, 1955St. Albans Cem.BaltimoreMd.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

10-20 St.John H. TaylorMs. Katie R. WilliamsSilver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1000

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09335

9341

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>7 mos. 14 days</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>664 Melvin Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>James Green</u>				4. DATE OF DEATH (Month) <u>10</u> (Day) <u>6</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE last birthday <u>85?</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				13. FATHER'S NAME <u>James Green</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Annie Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>			
17. INFORMANT & ADDRESS <u>Hospital Records</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>023X</u> IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Lues</u>							
19a. DATE OF OPERATION -----		19b. MAJOR FINDINGS OF OPERATION -----				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) -----		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) -----			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) -----		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? -----			
22. I hereby certify that I attended the deceased from <u>7/5</u>, 19 <u>55</u>, to <u>10/6</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>10/6</u>, 19 <u>55</u>, and that death occurred at <u>8:05a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>George P. Phillips</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>10/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Int. Auburn Cemt</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>Oct 13/1955</u>		REGISTRAR'S SIGNATURE <u>Katherine M. Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Miss. Katie R. Williams</u>			
DATE				ADDRESS <u>322 W. Schroeder St.</u>			

CERTIFICATE OF DEATH

Doc. No. 100

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. MANNER OF DEATH (Print or Write)

9. TIME OF DEATH (Print or Write)

10. PLACE OF DEATH (Print or Write)

11. SIGNATURE OF PHYSICIAN (Print or Write)

12. SIGNATURE OF REGISTRAR (Print or Write)

13. SIGNATURE OF WITNESS (Print or Write)

14. SIGNATURE OF DECEASED (Print or Write)

15. SIGNATURE OF NEXT OF KIN (Print or Write)

16. SIGNATURE OF CLERGYMAN (Print or Write)

17. SIGNATURE OF MINISTER (Print or Write)

18. SIGNATURE OF CHURCH WARDEN (Print or Write)

19. SIGNATURE OF BURIAL SOCIETY (Print or Write)

20. SIGNATURE OF FUNERAL HOME (Print or Write)

21. SIGNATURE OF CEMETERY (Print or Write)

22. SIGNATURE OF INTERVIEWER (Print or Write)

23. SIGNATURE OF INTERVIEWER (Print or Write)

24. SIGNATURE OF INTERVIEWER (Print or Write)

25. SIGNATURE OF INTERVIEWER (Print or Write)

26. SIGNATURE OF INTERVIEWER (Print or Write)

27. SIGNATURE OF INTERVIEWER (Print or Write)

28. SIGNATURE OF INTERVIEWER (Print or Write)

29. SIGNATURE OF INTERVIEWER (Print or Write)

30. SIGNATURE OF INTERVIEWER (Print or Write)

31. SIGNATURE OF INTERVIEWER (Print or Write)

32. SIGNATURE OF INTERVIEWER (Print or Write)

33. SIGNATURE OF INTERVIEWER (Print or Write)

34. SIGNATURE OF INTERVIEWER (Print or Write)

35. SIGNATURE OF INTERVIEWER (Print or Write)

36. SIGNATURE OF INTERVIEWER (Print or Write)

37. SIGNATURE OF INTERVIEWER (Print or Write)

38. SIGNATURE OF INTERVIEWER (Print or Write)

39. SIGNATURE OF INTERVIEWER (Print or Write)

40. SIGNATURE OF INTERVIEWER (Print or Write)

41. SIGNATURE OF INTERVIEWER (Print or Write)

42. SIGNATURE OF INTERVIEWER (Print or Write)

43. SIGNATURE OF INTERVIEWER (Print or Write)

BUREAU V. 3

9551 AT 100 25 OCT 17 1955

RECEIVED

Mr. Martin K. Williams

RECEIVED

9342

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>30 months</u>		TOWN <u>Baltimore City</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>10</u> <u>Crownsville State Hospital</u>				<u>Not known</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Maggie</u> <u>Gross</u>				<u>10</u> <u>22</u> <u>19 55</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>Negro</u>		<u>Widow?</u>		<u>Unknown</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>68?</u> yrs.		Months <u>—</u> Days <u>—</u>		Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Unknown</u>				<u>— — —</u>		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
<u>U. S.</u>				<u>William Nick</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
<u>Mary Addie Gross</u>				<u>Unk.</u> <u>Unk.</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS			
<u>Unk.</u>				<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Myocardial Degeneration</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Brain Syndrome associated with Senile Brain</u> <u>5 years</u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>— — — —</u>				<u>Disease</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>— — — —</u>		<u>— — — —</u>		<u>— — — —</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>— — — —</u>		<u>M.</u>		<u>— — — —</u>			
22. I hereby certify that I attended the deceased from <u>4/20</u> , 19 <u>53</u> , to <u>10/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/22</u> , 19 <u>55</u> , and that death occurred at <u>8:55a.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict, M. D.</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>			
DATE <u>10/22/55</u>				DATE SIGNED <u>10/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>REMOVAL</u>		<u>10/26/55</u>		<u>V OF M. MED SCHOOL</u>		<u>29 SCREEN ST MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>Oct. 28, 1955</u>		<u>Eatherine M. Joyce</u>		<u>DIPPEL BRIS 1800 E. HANOVER</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

002232

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

0012

1. Name of deceased

John H. Smith

2. Date of death

May 15, 1955

3. Place of death

Home

4. Age at death

68 years

5. Sex

Male

6. Race

White

7. Marital status

Married

8. Occupation

Teacher

9. Cause of death

Heart disease

10. Signature of physician

Dr. J. H. Smith

11. Signature of registrar

John H. Smith

12. Date of registration

May 15, 1955

13. Place of registration

Home

14. Signature of informant

John H. Smith

15. Date of information

May 15, 1955

16. Place of information

Home

17. Signature of informant

John H. Smith

18. Date of information

May 15, 1955

19. Place of information

Home

20. Signature of informant

John H. Smith

21. Date of information

May 15, 1955

22. Place of information

Home

BUREAU V. E.

2 MAY 1 1955

RECEIVED

RECEIVED

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9344

CERTIFICATE OF DEATH

09338

Item 9, FilmG188 10-31-55 et

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN		CITY OR TOWN	
TOWN <u>Crownsville</u>		<u>4yrs. 7mo. 22days</u>		TOWN <u>Baltimore City</u>		<u>3v01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>915 Fayette Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ella</u>		(Middle) <u>Mae</u>		(Last) <u>Hardy</u>		(Month) <u>10</u> (Day) <u>14</u> (Year) <u>19 55</u>	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED,		8. DATE OF BIRTH	
<u>Female</u>		<u>Negro</u>		<u>Widowed</u>		<u>Approx. 55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Sub-Rent Housing</u>		<u>-----</u>		<u>South Carolina</u>		<u>United States</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Rev. Andy Means</u>				<u>Ella Lue Kute</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>Unknown</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
18. MEDICAL CERTIFICATION							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia recurrent</u> <u>Known for 6 mo</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(B) <u>Meningo-vascular syphilis</u> <u>" " 5 yrs</u>							
(C) <u>Psychosis - Decubital ulcers</u> <u>" " 5 yrs</u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>-----</u>				<u>-----</u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		21d. HOW DID INJURY OCCUR?	
<input type="checkbox"/>		<input type="checkbox"/>		<u>-----</u>		<u>-----</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		<u>-----</u>	
<u>-----</u>		<u>M.</u>		<u>-----</u>		<u>-----</u>	
22. I hereby certify that I attended the deceased from <u>1/2/</u> , 19 <u>55</u> , to <u>10/14/</u> , 19 <u>55</u> , that I last saw the deceased <u>alive on</u> <u>10/14/</u> , 19 <u>55</u> , and that death occurred at <u>8:30A</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Hildegard H. Reissmann</u>				DATE SIGNED <u>10/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
<u>BURIAL</u>				<u>10-18-55 MT. CALVARY CEM. A.A. County Md.</u>			
25. FUNERAL DIRECTOR'S SIGNATURE				26. ADDRESS			
<u>Therese M. Jagers</u>				<u>Mrs. Robt. A. Elliott & Daughter</u>			
DATE <u>Oct. 18, 1955</u>				<u>1129 N. Caroline St</u>			

NOTIFICATION

When a death occurs, the coroner or medical examiner must file a report with the health department. This report is used to determine the cause of death and to prevent future deaths. The health department also issues a death certificate, which is a legal document that proves the death of a person. The death certificate is used for many purposes, including settling estates, claiming life insurance, and determining eligibility for social security benefits. The health department also keeps a record of all deaths in the community, which is used to monitor public health trends and to plan health care services.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

00038

Form 10-1-55

1. PLACE OF DEATH

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF CORONER

11. SIGNATURE OF MEDICAL EXAMINER

12. SIGNATURE OF WITNESS

13. SIGNATURE OF DEATH REGISTRAR

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF VENDOR

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CHURCH

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

BUREAU V. 1

OCT 18 1955

RECEIVED

Richard Harold Fine

10-10-55

10-10-55

10-10-55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9317

CERTIFICATE OF DEATH

09339

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u> COUNTY <u>G. A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>	
TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		TOWN <u>Annapolis</u>		TOWN <u>Odenton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. General Hosp.</u>				STREET ADDRESS <u>A. A. General Hosp.</u>			
3. NAME OF DECEASED (First) <u>Betty</u> (Middle) <u>Marie</u> (Last) <u>Haris</u>				4. DATE OF DEATH (Month) <u>10</u> (Day) <u>20</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>JS</u>		8. DATE OF BIRTH <u>10-18-55</u>	
9. AGE last birthday <u>2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>None</u>		11. KIND OF BUSINESS OR INDUSTRY		12. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>	
13. FATHER'S NAME <u>Isaac Brown</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Harris</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Hosp Records</u>		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE (A) <u>760.0</u>		ANTecedent CAUSE(S) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Unknown</u>		(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		19b. MAJOR FINDINGS OF OPERATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/18</u>, 19<u>55</u>, to <u>10/20</u>, 19<u>55</u>, that I last saw the deceased alive on <u>10/20</u>, 19<u>55</u>, and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Harold H. Johnson</u> M.D.				DATE SIGNED <u>10/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>Forest</u>		LOCATION (City, town, or county) (State) <u>Odenton, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. C. Brunch</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>21, Md</u>	

2005151404

CERTIFICATE OF DEATH

1917

Reg. Off. No.

LEGAL ACQUAINTANCE WITH DECEASED

NAME OF DECEASED

Wm. C. Thompson

Wm. C. Thompson

Wm. C. Thompson

Wm. C. Thompson

10-18-22

10-18-22

10-18-22

Wm. C. Thompson

Wm. C. Thompson

Wm. C. Thompson

Wm. C. Thompson

Wm. C. Thompson

Wm. C. Thompson

Wm. C. Thompson

Wm. C. Thompson

BUREAU V. 8

BUREAU V. 8

Oct 25 1922

Wm. C. Thompson

Wm. C. Thompson

Wm. C. Thompson

REGISTRATION

RECEIVED BY THE REGISTRAR OF DEATHS, ALABAMA STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, OCTOBER 25, 1922.

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9345

CERTIFICATE OF DEATH

09340

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Millersville (Rural)</u>		LENGTH OF STAY (in this place) <u>Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Md.</u>		TOWN <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sand's Nursing Home</u>				STREET ADDRESS <u>505 Manor Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Anna Elorine Hilling</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 11, 1955</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 31, 1906</u>	
9. AGE last birthday <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Newport News, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>R. W. Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Noma Atkins</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Mr. John Hilling, same as 2</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>14 years</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>345X</u> IMMEDIATE CAUSE (A) <u>Multiple Sclerosis</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 11, 1955</u> , to <u>Sept 1, 1955</u> , that I last saw the deceased alive on <u>Sept 1, 1955</u> , and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>James M. Joyce</u>				ADDRESS (Street, city, town, state) <u>505 Manor Road, Glen Burnie, Md.</u>			
DATE <u>Oct 12, 1955</u>				DATE SIGNED <u>10-11-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>10/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula Cemetery</u>		LOCATION (City, town, or county) (State) <u>Newport News, Virginia</u>	
24. REC'D BY REGISTRAR <u>John M. Joyce</u>		REGISTRAR'S SIGNATURE <u>John M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James M. Joyce</u>		ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>	

2000

2005 52 4

1994

100

BUREAU

1955-85

REVISED

MARYLAND

9346

CERTIFICATE OF DEATH

09341
STATE DEPARTMENT OF HEALTH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Jeannette</u> <u>md.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Old County</u> TOWN <u>10 mo</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>_____</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Jeannette</u> COUNTY <u>Ad Co</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jeannette</u> TOWN <u>_____</u> STREET ADDRESS (If rural, give location) <u>_____</u>	
3. NAME OF DECEASED (Type or Print) <u>Margaret S Jenkins</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>1</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>80</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Belle md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>us</u>	
13. FATHER'S NAME <u>Adam Meyers</u>		14. MOTHER'S MAIDEN NAME <u>Anna Meyers Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>_____</u>		16. SOCIAL SECURITY No. <u>_____</u>	
17. INFORMANT AND ADDRESS <u>Mrs. A. Zaluski</u>			

18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH410X
Immediate cause(a) Coronary occlusion

Antecedent cause(s)

(b) Chronic Mitral Insufficiency

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21 yr

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>_____</u>	(CITY OR TOWN) <u>_____</u>	(COUNTY) <u>_____</u>	(STATE) <u>_____</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>_____</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>_____</u>		

20. AUTOPSY?

Yes ☐ No ☒22. I hereby certify that I attended the deceased from 11/22, 1954, to 10/1, 1955, that I last saw the deceasedalive on 9-30, 1953, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE

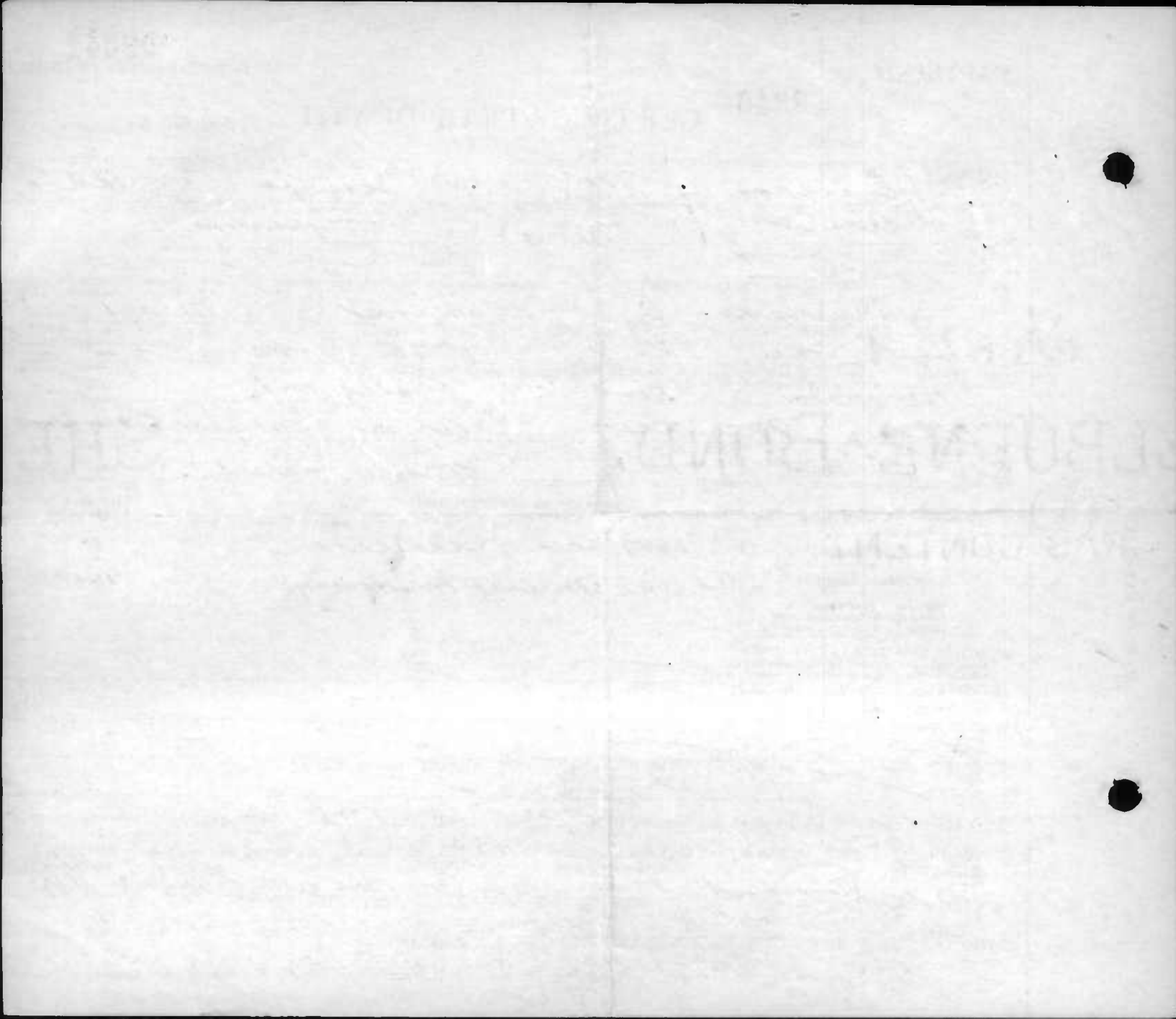
(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>10/4/55</u>	NAME OF CEMETERY OR CREMATORY <u>BACTIMORE</u>	LOCATION (City, town, or county) <u>BACTIMORE, MD.</u>	(State) <u>MD.</u>
DATE REC'D BY LOCAL REG. <u>10-3-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC.</u>		ADDRESS <u>715 LIGHT ST.</u>

MARGIN RESERVED FOR BINDING



9347

10417

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Anne Arundel		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Shadyside		LENGTH OF STAY (in this place) 56		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Shadyside			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) 1			
3. NAME OF DECEASED: (Type or Print)		(First) Ernest		(Middle)		(Last) Johnson	
5. SEX: M		6. COLOR OR RACE: C		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: May 1, 1899	
9. AGE last birthday: 56 yrs.		4. DATE OF DEATH Oct. 25		(Month) 25		(Year) 19 55	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Waterman		10b. KIND OF BUSINESS OR INDUSTRY: oystering		11. BIRTHPLACE (State or foreign country): Shadyside		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Albert Johnson				14. MOTHER'S MAIDEN NAME: Elizabeth Holland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): yes		(If Yes, give war or dates of service) WWI		16. SOCIAL SECURITY No.: 217-18-5043		17. INFORMANT & ADDRESS: Daniel Johnson, Shadyside	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
434.2 Immediate cause (a) Cardiac failure						? or immediate	
DUE TO						ate	
Antecedent cause(s) (b) Patient apparently died in his sleep unattended							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) History of asthma for many years							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE F.D. Hendricks		Shadyside, Md. M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Oct. 28/55		NAME OF CEMETERY OR CREMATORY St. Pauls		LOCATION (City, town, or county) (State) Shadyside, Md.	
DATE REC'D BY LOCAL REG. Oct. 27, 1955		REGISTRAR'S SIGNATURE I. B. Dent		24. FUNERAL DIRECTOR Bernard Hardesty, Galesville, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A15A - 5 - 53

11/17/55 mb

BUREAU V. S.

NOV 22 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **1** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09343

9348

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Anne Arundel</u>	<u>CROWNSVILLE</u> MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	LENGTH OF STAY (In this place) <u>2 1/2 mos</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERSTONE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CROWNSVILLE STATE Hospital</u> <u>10 CROWNSVILLE, Md</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Mollie</u> (First) <u>Johnson</u> (Middle) (Last)		4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>29</u> (Year) <u>1953</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>12-25-1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Unknown</u>
13. FATHER'S NAME <u>NOT KNOWN Henry Brown</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN Mary Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS <u>WALTER JOHNSON, CUMBERSTONE MD</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
199.9 IMMEDIATE CAUSE (A) <u>INANITION</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMATOSIS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTEROSCLEROSIS</u>			
19a. DATE OF OPERATION <u>NONE</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>8:30</u> , 19 <u>53</u> , to <u>10:29</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>10:29</u> , 19 <u>53</u> , and that death occurred at <u>10:48</u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>[Address]</u>	
		DATE SIGNED <u>10-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>11-3-55</u>	NAME OF CEMETERY OR CREMATORY <u>Chews Chapel</u>	LOCATION (City, town, or county) (State) <u>Quiversville, Md</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>	ADDRESS <u>108 Wash St Annapolis, Md</u>
DATE <u>11-3-55</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Intermediate Cause

Underlying Cause

ICD-9 Code

ICD-9 Code

ICD-9 Code

ICD-9 Code

ICD-9 Code

BUREAU V. S.

10-27

10-27

10-27

10-27

10-27

RECEIVED

NOTIFICATION

NOTIFICATION OF DEATH TO BE COMPLETED BY THE DECEASED'S NEXT OF KIN OR OTHER PERSON HAVING KNOWLEDGE OF THE DEATH. THIS FORM IS TO BE FILLED OUT AND RETURNED TO THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. WITHIN 10 DAYS OF THE DATE OF DEATH. IF THE DECEASED WAS A RESIDENT OF A FOREIGN COUNTRY, THIS FORM IS TO BE FILLED OUT AND RETURNED TO THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. WITHIN 10 DAYS OF THE DATE OF DEATH. IF THE DECEASED WAS A RESIDENT OF A FOREIGN COUNTRY, THIS FORM IS TO BE FILLED OUT AND RETURNED TO THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. WITHIN 10 DAYS OF THE DATE OF DEATH.

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09344

9318

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 7: Film G159-10-19-55L

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>M.D.</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>20 days</u>		CITY OR TOWN <u>Shore Acres - Rd x</u>		CITY OR TOWN <u>Shore Acres - Rd x</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hosp.</u>		STREET ADDRESS (If rural give location) <u>Shore Acres - Rd x</u>		STREET ADDRESS (If rural give location) <u>Shore Acres - Rd x</u>		STREET ADDRESS (If rural give location) <u>Shore Acres - Rd x</u>	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Mrs Lenora - Leonora Jones</u>				<u>10 14 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>Dec. 5 - 1889</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife - at home</u>		<u>at home</u>		<u>Baltimore Md</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN-NAME			
<u>Phillip Schaeffer</u>				<u>Elizabeth (P)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>216-01-3938-B</u>		<u>Mrs. Evelyn Repella (Home)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u>							
IMMEDIATE CAUSE (A)							
<u>MYOCARDIAL INFARCTION</u>							
ANTECEDENT CAUSE(S) (B)							
<u>PERICARDITIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
<u>4. HYPERTENSIVE C.V. DISEASE</u>							
<u>6. Generalized Arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 20 Sept 55 to 14 Oct 55, that I last saw the deceased alive on 13 Oct 55, and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Robert R. Halpin M.D.</u>				<u>Severna Park Md</u>		<u>14 Oct 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Oct-17-1955</u>		<u>Trinity Cem</u>		<u>Balt Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct. 17, 1955</u>		<u>Norm J. French</u>		<u>Howard Evans</u>		<u>1405 Clarks St (30)</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9319

CERTIFICATE OF DEATH

09345

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		1 day		TOWN <u>Annapolis</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
57 <u>U.S. Naval Hospital</u>				<u>USNH, (Infant)</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Baby Boy Joselyn</u>				<u>10 17 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Cau.</u>	<u>Single</u>	<u>16 October, 1955</u>		Months	Days	Hours
						<u>17</u>	<u>27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Infant</u>		<u>Infant</u>		<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edwin Gary JOSELYN</u>				<u>Yleen Ione BLACK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>U.S. Naval Hospital, Annapolis, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
762.5 IMMEDIATE CAUSE (A) <u>Atelectasis with Immaturity #762.5</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>16 October, 1955</u> , to <u>17 October, 1955</u> , that I last saw the deceased alive on <u>17 October, 1955</u> , and that death occurred at <u>6:12A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James C. Hodges Jr.</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>James C. Hodges Jr. MD MC JSN</u>				<u>M.D.U.S. Naval Hospital, Annapolis, Md</u>		<u>10-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-20-55</u>		<u>Naval Academy</u>		<u>Annapolis Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>OCT 19 1955</u>		<u>J. Hodges</u>		<u>John W. Taylor</u>		<u>Annapolis Md</u>	

2005251323

00317

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

Non-Resident

1. DECEASED'S RESIDENCE (When in U.S.)

MARYLAND

2. DECEASED'S NAME (Full)

3. DECEASED'S SEX

4. DECEASED'S AGE

5. DECEASED'S OCCUPATION

6. DECEASED'S CAUSE OF DEATH

7. DECEASED'S PLACE OF DEATH

8. DECEASED'S DATE OF DEATH

9. DECEASED'S TIME OF DEATH

10. DECEASED'S SIGNATURE

11. DECEASED'S ADDRESS

12. DECEASED'S CITY

13. DECEASED'S COUNTY

14. DECEASED'S STATE

15. DECEASED'S ZIP CODE

16. DECEASED'S SOCIAL SECURITY NUMBER

17. DECEASED'S MARITAL STATUS

18. DECEASED'S DATE OF BIRTH

19. DECEASED'S PLACE OF BIRTH

20. DECEASED'S DATE OF ENTRY INTO U.S.

21. DECEASED'S PLACE OF ENTRY INTO U.S.

22. DECEASED'S DATE OF DEPARTURE FROM U.S.

23. DECEASED'S PLACE OF DEPARTURE FROM U.S.

24. DECEASED'S DATE OF RETURN TO U.S.

25. DECEASED'S PLACE OF RETURN TO U.S.

26. DECEASED'S DATE OF DEATH

27. DECEASED'S PLACE OF DEATH

28. DECEASED'S DATE OF DEATH

29. DECEASED'S PLACE OF DEATH

30. DECEASED'S DATE OF DEATH

31. DECEASED'S PLACE OF DEATH

32. DECEASED'S DATE OF DEATH

33. DECEASED'S PLACE OF DEATH

34. DECEASED'S DATE OF DEATH

35. DECEASED'S PLACE OF DEATH

BUREAU V. 2

OCT 21 1955

RECEIVED

9349

10418
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>AA</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Rural Annapolis</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>DRURY</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <i>Alexander</i> (Middle) (Last) <i>Kelly</i>		(Month) (Day) (Year) <i>10 - 28 1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>Widowed</i>	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify): <i>Colored</i>	8. DATE OF BIRTH: <i>March 1906</i>
9. AGE last birthday: <i>49</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>Carbonton N.C</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Frige</i>	
11. FATHER'S NAME: <i>John Kelly</i>		12. MOTHER'S MAIDEN NAME: <i>Ida Brewer</i>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		14. SOCIAL SECURITY No.: <i>?</i>	
15. (If Yes, give war or dates of service) <i>no</i>		16. INFORMANT & ADDRESS: <i>Raleigh N.C</i> <i>Melissa Curtis, 619 Tower St</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <i>Gunshot wound of Chest</i>			
Antecedent cause(s) (b) <i>Massive Thoracic Hemorrhage</i>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <i>2</i>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		(State)	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>William Updell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>11-6-55</i> M. D. ASSISTANT MEDICAL EXAM. <i>11-6-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>Nov 16/55</i>	NAME OF CEMETERY OR CREMATORY: <i>Moses</i>	LOCATION (City, town, or county) (State): <i>Drury Md</i>
DATE REC'D BY LOCAL REG. <i>Nov 16, 1955</i>	REGISTRAR'S SIGNATURE: <i>Chas. West William</i>	24. FUNERAL DIRECTOR: <i>Bernard Hardisty Galmall</i> ADDRESS: <i>Cal</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 21 1955

BUREAU V. S.

09347

9350

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X Ft Geo G Meade		7 years		Baltimore		3401.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Army Hospital				STREET ADDRESS (If rural give location)			
50 2309 W. Lanvale St.				2309 W. Lanvale St.			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
ROLAND BERNARD KENNER				October 15 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Negro	single	15 October 1955		Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
none				Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Roland Bernard Kenner				Miriam Braxton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		none		Mother 2309 W. Lanvale St. Balto. Md.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
762.5 IMMEDIATE CAUSE (A)				Atelectasis Atelectasia			
ANTECEDENT CAUSE(S) DUE TO				Prematurity Prematurity			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
				INTERVAL BETWEEN ONSET AND DEATH			
				5 hrs 17 min			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 15 Oct 1955, to 15 Oct 1955, that I last saw the deceased alive on 15 Oct 1955, and that death occurred at 2:02 P.M. from the causes and on the date stated above.							
SIGNATURE EDWIN T. COOKE		FT MEADE, AA		ADDRESS (Street, city, town, state)		DATE SIGNED	
Edwin T. Cooke		M.D. Ft. Meade A.H.		15 Oct 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		18 October 1955		Post Cemetery		Fort George G. Meade Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 17 Oct 1955		HARRY G. SCH, CWO, USA		Chaplain Quigley		Fort G.G. Meade, Md.	

2005245301

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Form No. 10

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH

AGE
SEX
RACE
MARRIAGE

EDUCATION
OCCUPATION
HABIT OF SMOKING

PREVIOUS ILLNESS
CAUSE OF DEATH
MANNER OF DEATH

DATE OF BIRTH
PLACE OF BIRTH
DATE OF ENTRY INTO STATE

DATE OF DEATH
PLACE OF DEATH
DATE OF BURIAL

DATE OF INTERMENT
PLACE OF INTERMENT
DATE OF CREMATION

DATE OF CREMATION
PLACE OF CREMATION
DATE OF BURIAL

DATE OF BURIAL
PLACE OF BURIAL
DATE OF CREMATION

DATE OF CREMATION
PLACE OF CREMATION
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DATE OF BURIAL
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PLACE OF CREMATION
DATE OF BURIAL

DATE OF BURIAL
PLACE OF BURIAL
DATE OF CREMATION

DATE OF CREMATION
PLACE OF CREMATION
DATE OF BURIAL

BUREAU V. 2

OCT 20 1955

RECEIVED

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9320

CERTIFICATE OF DEATH

09348

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		STATE <u>Virginia</u>		COUNTY <u>Fauquier</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
10 TOWN <u>Annapolis</u>		6 weeks		TOWN <u>Delaplane</u>		83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
63 <u>Anne Arundel General Hospital</u>				✓			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>DANIEL BROWN KERFOOT</u>				<u>October 19 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>May 12, 1874</u>	<u>81</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Farmer</u>		<u>own farm</u>		<u>Delaplane, Va</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown Dodge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>801 West St. Mrs E.B. Sutphin, Daughter, Annapolis, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
490X IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>10 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>20 days</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 10, 19 55</u>, to <u>Oct. 19, 19 55</u>, that I last saw the deceased alive on <u>Oct. 18, 19 55</u>, and that death occurred at <u>3:55 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John R. Hederman</u>				ADDRESS (Street, city, town, state) <u>M.D. 90 Cathedral St., Annapolis, Md.</u>			
DATE <u>10-20-55</u>				DATE SIGNED <u>10/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-22-55</u>		<u>Ivhill Cemetery</u>		<u>Upperville, Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>10-20-55</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>	

INSTRUCTIONS

1. This form is to be filled out by the physician or other person who has attended the deceased. It should be filled out as soon as possible after death, and should be submitted to the local health department or to the Bureau of Health Statistics, Department of Health, State of Maryland, as soon as possible after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 10

10828

21

SEE CIV. 112

MARITAL HISTORY (MARRIAGE OR SEPARATION)

NAME OF DECEASED: [REDACTED]

DATE OF BIRTH: [REDACTED]

PLACE OF BIRTH: [REDACTED]

SEX: [REDACTED]

CAUSE OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED]

TIME OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

CAUSE OF DEATH: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

BUREAU V. E.

OCT 24 1955

RECEIVED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

09349

9351

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH - COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE		3. USUAL RESIDENCE (HOME) OF DECEASED - COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural, give location)	
208 Maple Lane N.W.		Same		Same	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		5. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)		(Month) (Day) (Year)	
Francis Earl Lewis		Oct. 20th. 1955		19	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	
Male		White		Married	
8. DATE OF BIRTH		9. AGE last birthday		10. MONTHS	
12/26/93		61 yrs.		Days	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. HOURS	
Davis, West Virginia.		U.S.A.		Min.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
J. Hamilton Lewis		Cornelia G. Carter		No	
16. SOCIAL SECURITY No.		17. INFORMANT		18. MEDICAL CERTIFICATION	
52059220		Mrs. M. Marguerite Lewis, (wife.)		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Coronary Occlusion		Sudden	
Immediate cause (a) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
Injury occurred While at work Not while at work			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title)		DATE SIGNED	
Gustaf H. Paulsen, Deputy		10/20/55	
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
Burial		Stevensville Cemetery	
DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR ADDRESS	
October 22, 1955		T. W. Singleton - Glen Burnie, Md.	

10000

1955

BUREAU V. S.

OCT 26 1955

RECEIVED

9352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY AY.	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville		LENGTH OF STAY (in this place) 8 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sann's Nursing Home				STREET ADDRESS (If rural give location) General's Highway			
3. NAME OF DECEASED: (First) Margaret (Middle) Lowman (Last)				4. DATE OF DEATH: 10/13/55 19			
5. SEX: Female.		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow		8. DATE OF BIRTH: 5/12/81	
9. AGE last birthday: 74 yrs.		10. BIRTHPLACE (State or foreign country): Baltimore Md.		11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if Housewife				10b. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Baltimore Md.	
13. FATHER'S NAME: ?				14. MOTHER'S MAIDEN NAME: ?			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs. Lillian M. Merson, Crownsville, Md.	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X Immediate cause (a) Cerebral Hemorrhage over		10 days
Antecedent causes (s) (b) Right hemiplegia		" "
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) Hypertension		?

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, office bldg., etc.)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
		HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/6/55 , 19....., to 10/13/55 , 19....., that I last saw the deceased alive on 10/11/55 , 19....., and that death occurred at 5:00 A.M. , from the causes and on the date stated above.			
SIGNATURE Eustace N. Paulsen		ADDRESS Glen Burnie, Md.	
DATE SIGNED 10/14/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Oct. 15, 1955	
NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		LOCATION (City, town, or county) (State) R.F.D. Brooklyn Maryland	
DATE REC'D BY LOCAL REGISTRAR Oct 13, 1955		REGISTRAR'S SIGNATURE R.V. Singleton	
		24. FUNERAL DIRECTOR Glen Burnie, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 18 1955

RECEIVED

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09351

9353

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Annæ Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riva, Md.</u> TOWN <u>Riva, Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riva, Md.</u> OR TOWN <u>Riva, Md.</u> STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>PERCY</u> <u>EMMONS</u> <u>LYNDON</u> (First) (Middle) (Last)		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 29, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	11. BIRTHPLACE (State or foreign country) <u>Mass.</u>
13. FATHER'S NAME <u>Weston R. Lyndon</u>		14. MOTHER'S MAIDEN NAME <u>Florance Emmons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT & ADDRESS <u>Gail R. Lyndon #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>UNKNOWN</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19.2.26.</u> , 19 <u>55</u> , to <u>26.2.55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>26.2.55</u> , 19 <u>55</u> , and that death occurred at <u>11 P.</u> M. from the causes and on the date stated above. SIGNATURE <u>Edward A. Beck</u> M.D. <u>41 Southgate Ave Annapolis 17 Md</u> ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>10/29/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>	
24. REC'D BY REGISTRAR DATE <u>10/29/55</u>		REGISTRAR'S SIGNATURE <u>Edward Hollinson</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor and Sons</u>		ADDRESS <u>Annapolis, Md.</u>	

03321

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

03321

Reg. Dist. No.

LOCAL HEALTH OFFICER OR REGISTRAR

DECEASED

PLACE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

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1955-11-22

No.

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	October 15, 1955	Ivy Hill Cemetery	Laurel	Maryland
DATE REC'D BY LOCAL REG. October 12,	1955	REGISTRAR'S SIGNATURE W.L. SAYLOR, 1ST LT MSC	24. FUNERAL DIRECTOR DWITT DONALDSON	ADDRESS Laurel, Maryland

VS. A15A-5-53

30800

BUREAU V. S.

OCT 14 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **1** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9355

CERTIFICATE OF DEATH

09353

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY OR TOWN <u>Ft Geo G. MEADE, MD.</u>		LENGTH OF STAY <u>5 Hours</u>		CITY OR TOWN <u>Odenton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. ARMY HOSPITAL</u>				STREET ADDRESS <u>74 Monterey</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u>		(Middle) <u>LEO</u>		(Last) <u>Mc DONNELL Jr.</u>		(Month) <u>Oct</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12 Dec 1918</u>	9. AGE last birthday <u>36</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>US ARMY</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pittsburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James Leo McDonnell Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Anna Laura Kyle?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		(If Yes, give war or dates of service) <u>11420</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>wife</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>322.1 Pneumonia, Right upper lung</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Intoxication chronic, malnutrition and exposure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11 Oct 55</u> , to <u>12 Oct 55</u> , that I last saw the deceased alive on <u>12 Oct 55</u> , and that death occurred at <u>4:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. L. Saylor</u>				ADDRESS (Street, city, town, state) <u>USAH Ft. Geo. G. Meade, Md</u> DATE SIGNED <u>12 Oct 55</u>			
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>10-18-55</u>		NAME OF CEMETERY OR CREMATORY <u>Southside Cem.</u>		LOCATION (City, town, or county) (State) <u>Pittsburgh Pa.</u>	
24. REC'D BY REGISTRAR <u>W. L. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Cooke</u>		ADDRESS <u>Baltimore, Md.</u>			

210123456789

NOTICE TO THE PUBLIC: The following information is being furnished to the public for their information. It is not to be used for any other purpose. The information is being furnished to the public for their information. It is not to be used for any other purpose. The information is being furnished to the public for their information. It is not to be used for any other purpose.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Web. Dist. No.

1. PLACE OF DEATH		2. LOCAL RESIDENCE (NAME OF DECEASED)	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
3. DATE OF DEATH		4. DATE OF BIRTH	
OCTOBER 10, 1959		OCTOBER 10, 1959	
5. TIME OF DEATH		6. TIME OF BIRTH	
10:00 AM		10:00 AM	
7. PLACE OF BIRTH		8. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
9. CAUSE OF DEATH		10. MEDICAL CERTIFICATION	
HEART DISEASE		HEART DISEASE	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF DECEASED	
[Signature]		[Signature]	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF DECEASED	
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15. SIGNATURE OF DECEASED		16. SIGNATURE OF DECEASED	
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BUREAU V. S.

OCT 14 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

9356

2411 N. Charles Street, Baltimore

09354

Item 21 Film G187 10-17-55 and CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>Anne Arundle</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>A. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pumphrey</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pumphrey</u>	
TOWN <u>Pumphrey</u>		TOWN <u>Pumphrey</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>-</u>		STREET ADDRESS (If rural, give location) <u>134 Midland Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Lucille</u> (First) <u>Inez</u> (Middle) <u>Mears</u> (Last)		4. DATE OF DEATH <u>October 2</u> 19 <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 22, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>60</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Leato</u>		14. MOTHER'S MAIDEN NAME <u>Clara Polson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Sylvia Mears</u>		134 Midland Ave.	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
537 Immediate cause (a) <u>Chremia</u>			<u>4 days</u>
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
825 (b) <u>Acute Nephritis - Cardiac but not</u>			<u>7 days</u>
(c) <u>Abscess of parotid gland & neck</u>			<u>20 days</u>
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture of arm, shoulder & pelvis</u>			<u>40 days</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>contr. only</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Highway</u>	(CITY OR TOWN) <u>3</u>	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 23 55</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Passenger in car</u>	

22. I hereby certify that I attended the deceased from 10 Sept., 1955, to 1 Oct., 1955, that I last saw the deceased alive on 1 Oct., 1955, and that death occurred at 6:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

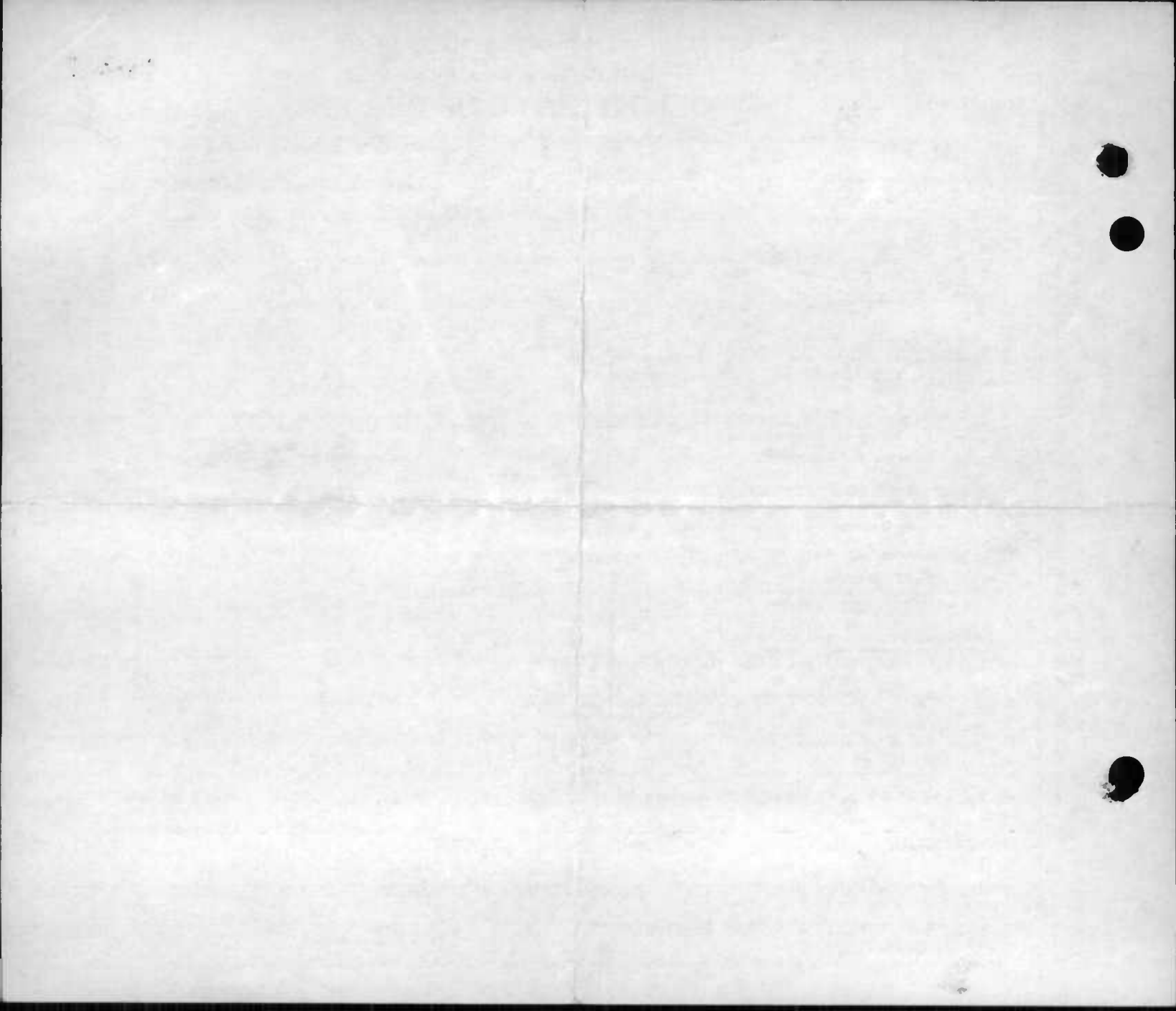
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Oct. 6, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>St. Ambrose</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>10-5-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>W. H. H. H.</u>	ADDRESS <u>1511 1st St. Hill Ave.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

9321

CERTIFICATE OF DEATH

09355

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		<u>3 yrs</u>		TOWN <u>Baltimore</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 <u>Home care, Annapolis, Md.</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>MIZEJEWSKI</u> (Last)				(Month) <u>Oct.</u> (Day) <u>31</u> (Year) <u>1955</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH	
						<u>about 78 yrs.</u>	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>farmer</u>		<u>Tomatoes</u>		<u>Poland</u>		<u>Poland</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
				<u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>none</u>		<u>Baltimore, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC HEART DISEASE</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED ARTERIOSCLEROSIS</u>				<u>unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>PARKINSON'S DISEASE</u>				<u>5 YRS.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>MARCH, 1955</u> , to <u>31 OCT., 1955</u> , that I last saw the deceased alive on <u>30 OCT., 1955</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Baldern A Beck MD</u>				<u>27 Oct 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Nov 2/55</u>		<u>St. Marys</u>		<u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov. 4, 1955</u>		<u>J. J. Daniel</u>		<u>Benedict Landuty - Baltimore, Md.</u>			

CERTIFICATE OF DEATH

100000

FILE NO. 11

DEATH CERTIFICATE NUMBER OF RECORD

NAME OF DECEASED
 SEX
 AGE
 RACE
 COLOR
 RELIGION
 MARRIAGE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

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DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RESIDENCE

BUREAU V. 2

NOV 7 1925

RECEIVED

INSTRUCTIONS

1. The death certificate is a legal document which must be filled out by the attending physician or the coroner. It is a record of the death and is used for statistical purposes. It is also used for the purpose of obtaining a burial permit. The death certificate must be filled out as soon as possible after the death and must be signed by the attending physician or the coroner. It must be filed with the local health department and a copy must be sent to the State Department of Health. The death certificate must be filled out in the following manner: 1. Name of deceased: Full name, including middle name and surname. 2. Sex: Male or Female. 3. Age: In years, months and days. 4. Race: White, Negro, or other. 5. Color: White, Negro, or other. 6. Religion: Catholic, Protestant, Jewish, or other. 7. Marriage: Single, Married, Widowed, Divorced. 8. Date of death: Day, month and year. 9. Time of death: Hour and minute. 10. Place of death: Home, Hospital, or other. 11. Cause of death: Full description of the cause of death. 12. Manner of death: Natural, Accidental, or Suicidal. 13. Education: High School, College, or other. 14. Occupation: Full description of the occupation. 15. Residence: Full address. 16. Date of birth: Day, month and year. 17. Place of birth: Full address. 18. Education: High School, College, or other. 19. Occupation: Full description of the occupation. 20. Residence: Full address. 21. Date of birth: Day, month and year. 22. Place of birth: Full address. 23. Education: High School, College, or other. 24. Occupation: Full description of the occupation. 25. Residence: Full address. 26. Date of birth: Day, month and year. 27. Place of birth: Full address. 28. Education: High School, College, or other. 29. Occupation: Full description of the occupation. 30. Residence: Full address. 31. Date of birth: Day, month and year. 32. Place of birth: Full address. 33. Education: High School, College, or other. 34. Occupation: Full description of the occupation. 35. Residence: Full address. 36. Date of birth: Day, month and year. 37. Place of birth: Full address. 38. Education: High School, College, or other. 39. Occupation: Full description of the occupation. 40. Residence: Full address. 41. Date of birth: Day, month and year. 42. Place of birth: Full address. 43. Education: High School, College, or other. 44. Occupation: Full description of the occupation. 45. Residence: Full address. 46. Date of birth: Day, month and year. 47. Place of birth: Full address. 48. Education: High School, College, or other. 49. Occupation: Full description of the occupation. 50. Residence: Full address. 51. Date of birth: Day, month and year. 52. Place of birth: Full address. 53. Education: High School, College, or other. 54. Occupation: Full description of the occupation. 55. Residence: Full address. 56. Date of birth: Day, month and year. 57. Place of birth: Full address. 58. Education: High School, College, or other. 59. Occupation: Full description of the occupation. 60. Residence: Full address. 61. Date of birth: Day, month and year. 62. Place of birth: Full address. 63. Education: High School, College, or other. 64. Occupation: Full description of the occupation. 65. Residence: Full address. 66. Date of birth: Day, month and year. 67. Place of birth: Full address. 68. Education: High School, College, or other. 69. Occupation: Full description of the occupation. 70. Residence: Full address. 71. Date of birth: Day, month and year. 72. Place of birth: Full address. 73. Education: High School, College, or other. 74. Occupation: Full description of the occupation. 75. Residence: Full address. 76. Date of birth: Day, month and year. 77. Place of birth: Full address. 78. Education: High School, College, or other. 79. Occupation: Full description of the occupation. 80. Residence: Full address. 81. Date of birth: Day, month and year. 82. Place of birth: Full address. 83. Education: High School, College, or other. 84. Occupation: Full description of the occupation. 85. Residence: Full address. 86. Date of birth: Day, month and year. 87. Place of birth: Full address. 88. Education: High School, College, or other. 89. Occupation: Full description of the occupation. 90. Residence: Full address. 91. Date of birth: Day, month and year. 92. Place of birth: Full address. 93. Education: High School, College, or other. 94. Occupation: Full description of the occupation. 95. Residence: Full address. 96. Date of birth: Day, month and year. 97. Place of birth: Full address. 98. Education: High School, College, or other. 99. Occupation: Full description of the occupation. 100. Residence: Full address.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09356

9322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		COUNTY <u>C.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		COUNTY <u>C.A.</u>	
TOWN <u>Annapolis</u>				STREET ADDRESS <u>Rt. 2 Box 550</u>		(If rural give location) <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. General Hosp.</u>							
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>George</u>		(Middle) <u>—</u>		(Last) <u>Murray</u>		(Month) <u>10</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>1-1-1895</u>	
9. AGE last birthday <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Skidmore, Md.</u>	
12. FATHER'S NAME <u>Nath Murray</u>		13. MOTHER'S MAIDEN NAME <u>Mary Snowden</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-052871</u>		17. INFORMANT'S ADDRESS <u>Oliver Murray 51 Chestnut St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>331X</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-1-55</u> to <u>10-17-55</u>, that I last saw the deceased alive on <u>10-17</u>, 19<u>55</u>, and that death occurred at <u>10-17</u> M., from the causes and on the date stated above.							
SIGNATURE <u>G. T. Allison</u>				DATE SIGNED <u>10-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>10-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Bread Neck</u>		LOCATION (City, town, or county) (State) <u>Skidmore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>V. Ormick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>Annapolis, Md.</u>	
DATE <u>10-22-55</u>							

CERTIFICATE OF DEATH

Reg. 127-1-1

1. Name of deceased

George (C.C.)
 Thompson

Age 22

10 15 22

Married

60

1-1-1892

William W. C.

Married

George Thompson

George (C.C.)

Thompson

Age 22

10 15 22

60

Married

George Thompson

William W. C.

Married

BUREAU V. S.

OCT 25 1892

George Thompson
 William W. C.
 10 15 22

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this time the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9357

CERTIFICATE OF DEATH

09357

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Pennsylvania</u> COUNTY <u>Clinton</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Ft Geo G Meade, Md.</u>		<u>11 days</u>		TOWN <u>Avis</u>		<u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 6</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Kathryn E. O'Donnell</u>				<u>October 31 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>Female</u>	<u>White</u>	<u>married</u>	<u>9 July 1895</u>	<u>60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>Pennsylvania</u>		<u>USA</u>	
13. FATHER'S NAME <u>John Kemmerer</u>				14. MOTHER'S MAIDEN NAME <u>Anna Moyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Husband: Edward W. O'Donnell, Avis, Pa.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>11 days</u>	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>MYO. CARDIAL INFARCTION</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>20 Oct</u> , 19 <u>55</u> , to <u>31 Oct</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>31 Oct 55</u> , 19 <u>55</u> , and that death occurred at <u>1700</u> M, from the causes and on the date stated above.							
SIGNATURE <u>HERBERT NEEDLEMAN</u>				ADDRESS (Street, city, town, state) <u>Ft GG Meade, Maryland</u> DATE SIGNED <u>31 Oct 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3 Nov 55</u>		NAME OF CEMETERY OR CREMATORY <u>Loganton Cemetery</u>		LOCATION (City, town, or county) (State) <u>Loganton, Pa.</u>	
24. REC'D BY REGISTRAR <u>WM. L. SAYLOR, 1/Lt MSC</u> DATE <u>1 Nov 55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

CERTIFICATE OF DEATH

1933

Post Office No. 27

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Duration of illness

8. Name of physician

9. Name of informant

10. Date of filing

BUREAU V. 2

NOV 8 1933

RECEIVED

11. Name of registrar

12. Signature of registrar

13. Date of filing

14. Name of hospital

15. Name of physician

16. Name of informant

17. Name of registrar

18. Name of physician

19. Name of informant

20. Name of registrar

21. Name of physician

22. Name of informant

23. Name of registrar

24. Name of physician

25. Name of informant

26. Name of registrar

27. Name of physician

28. Name of informant

29. Name of registrar

30. Name of physician

31. Name of informant

32. Name of registrar

UNRECORDED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09358

9358

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Massachusetts</u> COUNTY <u>Norfolk</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort George G. Meade</u>		<u>3 days</u>		TOWN <u>Brockton</u>		<u>58 x - 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location)		<u>24 Auburn Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Wayne Richard Ojala</u>				<u>October 18 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Caucasian</u>	<u>Single</u>	<u>October 15, 1955</u>	<u>3</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Richard John Ojala</u>				<u>Estelle Anne Eidler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mother, 24 Auburn Street, Brockton, Mass.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
795.5 IMMEDIATE CAUSE (A) <u>Unknown</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 Oct 55</u> to <u>18 Oct 55</u> , that I last saw the deceased alive on <u>18 Oct 55</u> , 19 <u>55</u> , and that death occurred at <u>12 noon</u> , from the causes and on the date stated above.							
SIGNATURE <u>HERBERT L. NEEDLEMAN, MC</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Herbert L. Needleman</u>				<u>Fort G.G. Meade, Md.</u>		<u>18 October 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>21 Oct 55</u>		<u>Post Cemetery</u>		<u>Fort Meade AA Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>19 Oct 55</u>		<u>HARRY CARPCH, CWO, USA</u>		<u>CHAPLAIN QUIGLEY, FT MEADE, MD.</u>			

VS A15C 1-55 10M

2005241433

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9359
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09359
Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>g.g.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Friendship</u>		<u>life</u>		TOWN <u>Friendship</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Minnie</u> <u>a.</u> <u>Qwings</u>				<u>10</u> <u>3</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Nov. 23 1867</u>	9. AGE last birthday: <u>87</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Henry Qwings</u>				14. MOTHER'S MAIDEN NAME: <u>Amelia Qwings</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mr. L. Ernest Qwings</u>			
				<u>1209 E Capitol St Wp</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							INTERVAL BETWEEN ONSET AND DEATH
<u>903.0</u> Immediate cause		(a) <u>Coronary occlusion</u> DUE TO					
Antecedent cause(s)		(b) <u>generalized arteriosclerosis -</u> DUE TO					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
				<u>Friendship</u> <u>g.g. Co</u> <u>md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10</u> <u>3</u> <u>55</u> <u>PM</u>		21e. INJURY OCCURRED While at work Not while at work <input type="checkbox"/> <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell on porch</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Emily A. Wilson</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct. 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		LOCATION (City, town, or county) (State) <u>Friendship</u> <u>Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 4, 1955</u>		REGISTRAR'S SIGNATURE <u>Elvis West Williams</u>		24. FUNERAL DIRECTOR <u>William H. Hutchins, Owings, Maryland</u>			

BUREAU V. S.

OCT 2 1955

RECEIVED

OCT 4 1955

Bureau

OCT 2 1955

Relationship Secretary

This

William H. Hatcher

9360

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>7yrs. 7mos. 23days</u>		TOWN <u>Baltimore City</u>		<u>3 Vol-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1011 Watson Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Paul</u> <u>Pitts</u>				<u>10</u> <u>29</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Single</u>	<u>1914?</u>	<u>41?</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Unknown</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Paul Pitts</u>				<u>Ida Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>002X</u> IMMEDIATE CAUSE (A) <u>Far Advanced Tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Known to us for 3 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
-		-		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
-		-		-			
22. I hereby certify that I attended the deceased from <u>3/6</u>, 19 <u>48</u>, to <u>10/29</u>, 19 <u>48</u>, that I last saw the deceased alive on <u>10/29</u>, 19 <u>48</u>, and that death occurred at <u>10:40a</u>, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		(L. Benedict, M. D.)		ADDRESS (Street, city, town, state)		DATE SIGNED	
		M.D.		<u>Crownsville, Md.</u>		<u>10/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>REMOVAL</u>		<u>NOV 3 1955</u>		<u>UOFM MEDICAL SCHOOL</u>		<u>295 GREENE ST MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>NOV 3 1955</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>1800 E Lombard St.</u>	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9361

CERTIFICATE OF DEATH

09361

Reg. Dist. No.

24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> MARYLAND				STATE <u>MD.</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>			
TOWN <u>Severna Park</u>				TOWN <u>Severna Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>40 Boone Trail</u>				STREET ADDRESS (If rural give location) <u>40 Boone Trail</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Jesse Thomas Ridgeway</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 15, 1955</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Nov 20 1898</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Harte</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give date or dates of service) <u>1942 Army</u>				16. SOCIAL SECURITY NO. <u>212-10-2326</u>		17. INFORMANT & ADDRESS <u>Mr. T. Nelson Haase 6827 Blenheim Rd.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE <u>420.1</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>① Myocardial Infarction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1500</u> to <u>1900</u> , that I last saw the deceased alive on <u>Oct 15</u> , 19 <u>55</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C. Hahn</u>		M.D. <u>Severna Park Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Maus.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
24. REC'D BY REGISTRAR <u>Oct. 19, 1955</u>		REGISTRAR'S SIGNATURE <u>Louis J. De Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tishner & Sons</u>		ADDRESS <u>Baltimore Md.</u>	

SHORT-TERM

1. Name of decedent: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Manner of death: [illegible]
6. Medical history: [illegible]
7. History of present illness: [illegible]
8. Post-mortem examination: [illegible]
9. Signature of physician: [illegible]
10. Signature of medical examiner: [illegible]
11. Signature of coroner: [illegible]
12. Signature of registrar: [illegible]
13. Date of filing: [illegible]
14. File number: [illegible]

CERTIFICATE OF DEATH

48381

11-1-1955

1. Name of decedent: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Manner of death: [illegible]

6. Medical history: [illegible]

7. History of present illness: [illegible]

8. Post-mortem examination: [illegible]

9. Signature of physician: [illegible]

10. Signature of medical examiner: [illegible]

11. Signature of coroner: [illegible]

12. Signature of registrar: [illegible]

13. Date of filing: [illegible]

14. File number: [illegible]

BUREAU V. 1

OCT 19 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09362

9323

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A. Co</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>A.A. Co</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>ANNAPOLIS</u>		<u>LIFE</u>		TOWN <u>ANNAPOLIS</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		1	
63 <u>A.A. General Hosp.</u>				<u>75 WATER ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>Deborah Ann Rogers</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10 21 1955</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>		8. DATE OF BIRTH <u>10-1-1955</u>	
9. AGE last birthday yrs. <u>20</u>		IF UNDER 1 YEAR Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min. <u>20</u>		IF UNDER 24 HRS. <u>20</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rudolph Rogers</u>				14. MOTHER'S MAIDEN NAME <u>Rosalie Matthews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>ANNA, Md Rosalie Matthews, 75 Water ST</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
764.0 IMMEDIATE CAUSE (A) <u>Acute abdominal insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Sepsis</u>				<u>1</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <u>Enteritis, acute</u>				<u>5</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>---</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>20 Oct</u> , 19 <u>55</u> , to <u>21 Oct</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>21 Oct</u> , 19 <u>55</u> , and that death occurred at <u>3:20 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>William Reese, II</u>		M.D. <u>Carol Ball</u>		ADDRESS (Street, city, town, state) <u>Ann Arbor, Mich</u>		DATE SIGNED <u>24 Oct 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-25-55</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		LOCATION (City, town or county) (State) <u>ANNAPOLIS, Md</u>	
24. REC'D BY REGISTRAR <u>---</u>		REGISTRAR'S SIGNATURE <u>William Reese, II</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II</u>		ADDRESS <u>108 N. Wash. St ANNAPOLIS, Md</u>	
DATE <u>Nov 1, 1955</u>		<u>900599099V110</u>					

3226

0912 21151111

72 457 NW 27

275909

2

101102

27-805

ROBERT MATTING

2000

BUREAU A.

1955

RECEIVED

10-23-01 1A-5C

William Reed Jr. 1044 Wash St
Hawthorne, Mo

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09363

9362

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie</u>		<u>5 yrs</u>		TOWN <u>Glen Burnie, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>604 Newfield Rd</u>				STREET ADDRESS (If rural give location) <u>Same</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CLARENCE ARTHUR SCHAUMLOEFFEL</u>				<u>Oct. 23</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>Married</u>	<u>July 19, 1912</u>	<u>43</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Book keeper</u>		<u>Dept Store</u>		<u>Balto., Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Geo. M. Schamloeffel (dec)</u>				<u>Theresa Schnitzler (dec)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>yes</u>		<u>W. W. II 1942-45</u>		<u>218-07-6487 Mrs Vivian Schamloeffel (wife) same address</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
199.9 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>Metastatic Tumor of Brain</u>				<u>8 mo</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
<u>Primary site unknown - probably</u>							
(C) DUE TO							
<u>Cancer of Lung -</u>				<u>approx 1 yr</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>9 May 1955</u>		<u>Cerebellar tumor</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u>No</u>		<u>No</u> in injury			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED (M. at work) (Not white at work)		21f. HOW DID INJURY OCCUR?			
<u>none</u>		<input type="checkbox"/> <input type="checkbox"/>		<u>I</u>			
22. I hereby certify that I attended the deceased from <u>Jan. 1955</u>, to <u>10-23</u>, 19<u>55</u>, that I last saw the deceased alive on <u>10-21</u>, 19<u>55</u>, and that death occurred at <u>11:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>H. F. Marmgate</u>		<u>Oct 26/55</u>		<u>Cedar Hill Cem.</u>		<u>Brooklyn, P.D.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		<u>L. J. DeAlba</u>		<u>R. J. Singleton</u>		<u>Glen Burnie, Md.</u>	
DATE		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct-28, 1955</u>		<u>L. J. DeAlba</u>		<u>R. J. Singleton</u>		<u>Glen Burnie, Md.</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

10000

Page One

Usual Residence of Deceased

Married and

Age

Sex

Color

Occupation

Education

Religion

Birth Date

Place of Birth

Time of Death

Place of Death

Cause of Death

Immediate Cause

Underlying Cause

Manner of Death

Medical Examination

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Witness

Signature of Deceased

Signature of Family

Signature of Neighbor

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

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Signature of Other

Signature of Other

Signature of Deceased

Signature of Family

Signature of Neighbor

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09364

9363

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>a a</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>a a</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<i>x</i> TOWN <i>Churchton</i>		<i>3 yrs</i>		TOWN <i>Churchton MD</i>		<i>x</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <i>Charles</i> (Middle) <i>Scott</i> (Last)				<i>Oct 22</i> 19 <i>55</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>M</i>	<i>C</i>	<i>Married</i>	<i>Mar. 9 1881</i>	<i>74</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Waterman</i>		<i>Computing</i>		<i>Shadyside Md</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Jacob Scott</i>				<i>Matilda Thompson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<i>-</i>		<i>Susie Scott Churchton Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <i>Acute Coronary Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis of the heart and blood vessels</i>				<i>2 years</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Heart disease</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct 17, 1955</i> , to <i>Oct 22, 1955</i> , that I last saw the deceased alive on <i>Oct 22, 1955</i> , and that death occurred at <i>3:50 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city, town, state) <i>110-Clay St. Baltimore Md</i>			
DATE <i>Oct 27, 1955</i>				DATE SIGNED <i>10/25/55</i>			
23. BURIAL, CREATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Oct 26 1955</i>		<i>Scott</i>		<i>Shadyside Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>D. B. Bent</i>		<i>[Signature]</i>		<i>Benard Hardisty</i>		<i>Galesville</i>	

EMOTIONAL

THE STATE OF MARYLAND, DEPARTMENT OF HEALTH - BALTIMORE 18
 I, the undersigned, being a duly qualified and licensed physician, do hereby certify that the within and foregoing death certificate was duly filled out and signed by me or by a duly qualified and licensed physician, and that the facts therein stated are true and correct to the best of my knowledge and belief.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]

2. SEX: [illegible] 3. AGE: [illegible] 4. DATE OF BIRTH: [illegible]
 5. PLACE OF BIRTH: [illegible] 6. OCCUPATION: [illegible]
 7. MARITAL STATUS: [illegible] 8. COLOR: [illegible]

9. DATE OF DEATH: [illegible] 10. PLACE OF DEATH: [illegible]

11. CAUSE OF DEATH: [illegible]

12. MANNER OF DEATH: [illegible]

13. SIGNATURE OF PHYSICIAN: [illegible]

14. SIGNATURE OF REGISTRAR: [illegible]

15. SIGNATURE OF WITNESS: [illegible]

16. SIGNATURE OF DECEASED: [illegible]

17. SIGNATURE OF NEXT OF KIN: [illegible]

18. SIGNATURE OF BURIAL OFFICIAL: [illegible]

19. SIGNATURE OF OTHER: [illegible]

*George Washington
 Washington
 Washington*

RECEIVED
 BUREAU A. B.
 OCT 10 1918

Oct 10 1918
 110-10-10-10

Oct 10 1918
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Oct 10 1918

9364

09365

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 20

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>ANNE ARUNDEL</u>	MARYLAND	STATE <u>D.C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Beverly Beach</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>WASH D.C.</u>	<u>47X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1301 Longfellow St. N.W.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Eleanor</u>	(Middle)	(Last) <u>SHANAHAN</u>	(Month) <u>10</u> (Day) <u>9</u> (Year) <u>19 55</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 1910</u>
9. AGE last birthday: <u>45</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Wholesale Buyer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Frederick Knapp</u>		14. MOTHER'S MAIDEN NAME: <u>Emily Muth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>17. INFORMANT & ADDRESS: <u>Carl Shanahan #2</u></u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
420.1 Immediate cause (a) <u>Coronary disease</u> DUE TO		<u>Instant</u>
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/9/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>Oct. 10, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>SEEDAR Hill</u>
DATE REC'D BY LOCAL REG. <u>10-11-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	LOCATION (City, town, or county) (State) <u>PRINCE GEORGE Co. Md.</u>
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>3831-GM Ave N.W.</u>

MARGIN RESERVED FOR BINDING

S. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Genevly Rosen
Helen H. Rosen

Woon D.C.

F. White
Thomas

BUREAU V. 2

OCT 17 1935

RECEIVED

Handwritten notes and signatures at the bottom of the page.

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9324

CERTIFICATE OF DEATH

09366

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> MARYLAND		STATE <u>Md.</u> COUNTY <u>Q. Q. Co.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place)		CITY OR TOWN <u>Annapolis</u> X		CITY OR TOWN <u>Annapolis</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Q. Q. Gen. Hosp.</u>		STREET ADDRESS (If rural, give location)		STREET ADDRESS <u>Q. Q. D #2 Annapolis</u>		STREET ADDRESS <u>Q. Q. D #2 Annapolis</u>	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
EMMA SHEAY				OCT 12 1955			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>MAY 28 1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MINNESOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN G NELSON</u>				14. MOTHER'S MAIDEN NAME <u>ANNA NELSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>7112 Thomas Dr. Bethesda 14, Md.</u>			
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Pericarditis</u>				16d			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Postcoronary myocardial infarction?</u>				14d. ?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/25/55</u> , to <u>10/12/55</u> , that I last saw the deceased alive on <u>10/11/55</u> , 19 <u>55</u> , and that death occurred at <u>3:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city, town, state) <u>M.D. 63 College Ave Annapolis</u>		DATE SIGNED <u>10/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>Oct 17 1955</u>		NAME OF CEMETERY OR CREMATORY <u>LITCHFIELD CEM</u>		LOCATION (City, town, or county) (State) <u>LITCHFIELD MINN.</u>	
24. REC'D BY REGISTRAR <u>10-12-55</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR - SON</u>		ADDRESS <u>ANAPOLIS MARYLAND</u>			

NOTIFICATION

1. Name of deceased: *John Doe*
2. Date of death: *Oct 14 1965*
3. Place of death: *Home*
4. Cause of death: *Heart Disease*
5. Manner of death: *Natural*
6. Age at death: *65*
7. Sex: *Male*
8. Race: *White*
9. Marital status: *Married*
10. Occupation: *Teacher*
11. Education: *High School*
12. Date of birth: *Oct 14 1900*
13. Place of birth: *USA*
14. Date of death: *Oct 14 1965*
15. Place of death: *Home*
16. Cause of death: *Heart Disease*
17. Manner of death: *Natural*
18. Age at death: *65*
19. Sex: *Male*
20. Race: *White*
21. Marital status: *Married*
22. Occupation: *Teacher*
23. Education: *High School*
24. Date of birth: *Oct 14 1900*
25. Place of birth: *USA*

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

10888

1. Name of deceased: *John Doe*

2. Date of death: *Oct 14 1965*

3. Place of death: *Home*

4. Cause of death: *Heart Disease*

5. Manner of death: *Natural*

6. Age at death: *65*

7. Sex: *Male*

8. Race: *White*

9. Marital status: *Married*

10. Occupation: *Teacher*

11. Education: *High School*

12. Date of birth: *Oct 14 1900*

13. Place of birth: *USA*

14. Date of death: *Oct 14 1965*

15. Place of death: *Home*

16. Cause of death: *Heart Disease*

17. Manner of death: *Natural*

18. Age at death: *65*

19. Sex: *Male*

20. Race: *White*

21. Marital status: *Married*

22. Occupation: *Teacher*

23. Education: *High School*

24. Date of birth: *Oct 14 1900*

25. Place of birth: *USA*

26. Date of death: *Oct 14 1965*

27. Place of death: *Home*

28. Cause of death: *Heart Disease*

29. Manner of death: *Natural*

30. Age at death: *65*

31. Sex: *Male*

32. Race: *White*

33. Marital status: *Married*

34. Occupation: *Teacher*

35. Education: *High School*

36. Date of birth: *Oct 14 1900*

37. Place of birth: *USA*

38. Date of death: *Oct 14 1965*

39. Place of death: *Home*

40. Cause of death: *Heart Disease*

41. Manner of death: *Natural*

42. Age at death: *65*

43. Sex: *Male*

44. Race: *White*

45. Marital status: *Married*

46. Occupation: *Teacher*

47. Education: *High School*

48. Date of birth: *Oct 14 1900*

49. Place of birth: *USA*

50. Date of death: *Oct 14 1965*

51. Place of death: *Home*

52. Cause of death: *Heart Disease*

53. Manner of death: *Natural*

54. Age at death: *65*

55. Sex: *Male*

56. Race: *White*

57. Marital status: *Married*

58. Occupation: *Teacher*

59. Education: *High School*

60. Date of birth: *Oct 14 1900*

61. Place of birth: *USA*

62. Date of death: *Oct 14 1965*

63. Place of death: *Home*

64. Cause of death: *Heart Disease*

65. Manner of death: *Natural*

66. Age at death: *65*

67. Sex: *Male*

68. Race: *White*

69. Marital status: *Married*

70. Occupation: *Teacher*

71. Education: *High School*

72. Date of birth: *Oct 14 1900*

73. Place of birth: *USA*

74. Date of death: *Oct 14 1965*

75. Place of death: *Home*

76. Cause of death: *Heart Disease*

77. Manner of death: *Natural*

78. Age at death: *65*

79. Sex: *Male*

80. Race: *White*

81. Marital status: *Married*

82. Occupation: *Teacher*

83. Education: *High School*

84. Date of birth: *Oct 14 1900*

85. Place of birth: *USA*

86. Date of death: *Oct 14 1965*

BUREAU V. 8

OCT 14 1965

RECEIVED

9365

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN <u>RAYNOR HEIGHTS</u>		<u>35 yrs.</u>		TOWN <u>RAYNOR HEIGHTS</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 EVELYN & FRANKLIN AVES.</u>				STREET ADDRESS (If rural give location) <u>EVELYN & FRANKLIN AVES.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>Annie</u> <u>MARTHA</u> <u>Snyder</u>				DATE OF DEATH: <u>10-28</u> <u>1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>FEMALE</u>		<u>WHITE</u>		<u>WIDOWED</u>		<u>December 5, 1883</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>71</u> yrs.		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Housewife</u>				<u>Domestic</u>		<u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY:				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Schwaht</u>				<u>Barbara K. Hoffman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>NO</u>				<u>NONE</u>		<u>Alton Snyder Evelyn & Franklin Aves.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>422.1</u>						<u>48 hr.</u>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>10 yrs.</u>	
(A) <u>Cardio-vascular Disease</u>							
DUE TO							
(B) <u>Arteriosclerosis</u>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>1947</u>	
19A. DATE OF OPERATION:						19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>1947</u> , 19....., to <u>10/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/28/55</u> , 19....., and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Chris L. Ball</u>				ADDRESS <u>M. D. Linthicum</u>		DATE SIGNED <u>10/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10-31-55</u>		<u>MEADOWRIDGE</u>		<u>Howard County Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>OCT 30 1955</u>		<u>George L. Schwab</u>		<u>George L. Schwab</u>		<u>2101 Redbank Ave.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. 2

NOV 2 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09369

9366

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town.) <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>3yrs. 1mo. 24days</u>		CITY (If outside corporate limits, write RURAL end give nearest town) <u>Baltimore City</u>		<u>3y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>641 N. Paca Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Viola Lamback Stewart</u>				4. DATE OF DEATH (Month) <u>10</u> (Day) <u>8</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>3/20/00</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> - - - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William Lamback</u>				14. MOTHER'S MAIDEN NAME <u>Lula Oliver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
199.9 IMMEDIATE CAUSE (A) <u>Cardiac arrest</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinomatosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u> - - </u>		19b. MAJOR FINDINGS OF OPERATION <u> - - - -</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/14</u> , 19 <u>52</u> , to <u>10/8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/8</u> , 19 <u>55</u> , and that death occurred at <u>7:00a</u> , from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict</u>		(L. Benedict, M. D.) ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>				DATE SIGNED <u>10/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>10-17-55</u>		DATE THEREOF <u>10-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Crownsville State Hosp.</u>		LOCATION (City, town, or county) (State) <u>Crownsville Md.</u>	
24. REC'D BY REGISTRAR DATE <u>OCT 17 1955</u>		REGISTRAR'S SIGNATURE <u>Mrs K-M. Joye</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arnold H. Eickert, M.D. Crownsville, Md.</u>			

Rev FS Joye

100-200

WESTERN STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
JAMES H. HARRIS		Male		45	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
New York City		Teacher		Heart Disease	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
October 10, 1918		10:30 AM		Home	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]	
13. NAME OF FUNERAL HOME		14. NAME OF BURIAL PLACE		15. NAME OF CEMETERY	
[Name]		[Name]		[Name]	

BUREAU V. 2

OCT 10 1918

RECEIVED

100-200

UNCLASSIFIED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

9325

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

09370

Items 8, 9, 13, 14 Film G188 11-1-55 et

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>Q. Q.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington D.C.</u> 47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>UNK</u>		STREET ADDRESS (If rural, give location) <u>UNK</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARCHETTA</u>	(Middle) _____	(Last) <u>STRANG</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>UNK</u> 10-4-34
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DANCER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ENTERTAINER</u>	
13. FATHER'S NAME <u>"UNK" Glen Strang</u>		14. MOTHER'S MAIDEN NAME <u>"UNK" Ina Dobson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>WHITE + COULTER FUNERAL HOME W. Va.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>850X</u> <u>Drowning</u>		<u>Several</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last		
(c) _____		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Bank (14th) burned</u> 02

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE Chas. Hault (Degree or title) MD ADDRESS Funkhals Rd DATE SIGNED 10/1/55

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>10/2/55</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. View Mem. Park</u>	LOCATION (City, town, or county) (State) <u>Richwood W. Va.</u>
DATE REC'D BY LOCAL REC. <u>Oct. 22, 1955</u>	RECEIVED BY SIGNATURE <u>U. Drunch</u>	24. FUNERAL DIRECTOR <u>WHITE + COULTER FUNERAL HOME</u>	ADDRESS <u>Richwood W. Va.</u>

BUREAU V. S.

OCT 31 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09371

Reg. Diat. No. 28

9357

1. PLACE OF DEATH:

County Anne Arundel
 City or town Gambrells
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Ten years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Gambrells
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Jacy B. Matthews Swift

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct 3, 1862 8. (c) If alive, give age 93 years

8. AGE: Years 93 Months Days If less than one day hrs. min.

9. Birthplace Baltimore City Md
 (Twp., county, and state)

10. Usual occupation Retired

11. Industry or business School Teacher

12. Name Jacy B. Matthews

13. Birthplace Baltimore Md

14. Maiden name Ruth Branson

15. Birthplace Va

16. Informant Rebecca W. Higgins

Address Gambrells Md

17. Charlottesville Va Date thereof Oct 27 1955
 (Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Burial

Location Harford Co., Md

18. Funeral director H. S. Bailey

Address Charlottesville Va

19. Oct 26 1955 Registrar C. R. Kirk
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1955

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1955 to Oct 24 1955
 and that I last saw him alive on Oct 24 1955

Immediate cause of death

Old Age

Due to

794X

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lucas H. MacNeenan

Address Millersville Md Date signed Oct 26 1955

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

NOV 3 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09372

9368

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY <u>Q. Q.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>Q. Q.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Severn</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Severn, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crystal Springs</u>		STREET ADDRESS (If rural, give location) <u>Crystal Springs</u>	
3. NAME OF DECEASED (Type or Print) <u>Sarah Talbot Talt</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>27</u> (Year) <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-14-1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>86</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Clara Casken-Crystal Springs-Severn, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>490x</u> Immediate cause (a) <u>Acute Lobar Pneumonia</u>		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>Generalized Atherosclerosis</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased on Sept 1, 55, 1955, that I last saw the deceased alive on Oct 26, 55, and that death occurred at 8 A.M. from the causes and on the date stated above.

SIGNATURE <u>JOSEPH L. Higgins</u>	(Degree or title)	ADDRESS <u>Baltimore</u>	DATE SIGNED <u>10-28-55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE TIME OF <u>10-31-55</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
DATE REC'D BY LOCAL REG. <u>10/31/55</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Thomas E. Nelson</u>	ADDRESS <u>13036 Baltimore Rd. Baltimore, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1898

Wm. H. ...
Capital ...
...
...

...
...

...
...
...

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09373

CERTIFICATE OF DEATH

Item 9, Film 188 10-31-55 et Item 3, Film 188 10-31-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>3yrs. 3mo. 19days</u>		TOWN <u>Baltimore City</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>912 Brooks Lane</u> ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Amos</u>		(Middle) <u>Thrower</u>		(Last) <u>Ames</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 7, 1889</u>	
9. AGE last birthday <u>66</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Edward Trower</u>				14. MOTHER'S MARDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
464X IMMEDIATE CAUSE (A) <u>Pulmonary embolism</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Phelibitis of left arm</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 24</u> , 19 <u>52</u> , to <u>October 13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 23</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict,)</u>		M.D. <u>Crownsville Maryland</u>		DATE SIGNED <u>Oct. 14, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Richard M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. H. Kelson</u>		ADDRESS <u>1348 Calhoun St</u>	
DATE <u>10/17/55</u>							

008733

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF DEVIL

25. SIGNATURE OF ANGELS

26. SIGNATURE OF DEMONS

27. SIGNATURE OF SPIRITS

28. SIGNATURE OF SOULS

29. SIGNATURE OF BODIES

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF DEVIL

25. SIGNATURE OF ANGELS

26. SIGNATURE OF DEMONS

27. SIGNATURE OF SPIRITS

28. SIGNATURE OF SOULS

29. SIGNATURE OF BODIES

REGISTERED

NOTICE: This certificate is a legal document and must be filed in the proper office. It is subject to the laws and regulations of the State of Maryland. The information provided on this certificate is for official use only and should not be used for any other purpose. The State of Maryland is not responsible for the accuracy of the information provided on this certificate. The user of this certificate is responsible for the accuracy of the information provided. The State of Maryland is not responsible for the accuracy of the information provided. The user of this certificate is responsible for the accuracy of the information provided.

BUREAU V. S.

OCT 18 1995

RECEIVED

10/18/95

9370

09374
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 20

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ANNE ARUNDEL MARYLAND		CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		STATE Md. COUNTY AA		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Friendship	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) CRYSTAL (Middle) E (Last) TUCKER				(Month) 10 (Day) -23 (Year) 1955			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: 8-16-1898	9. AGE last birthday: 57 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): housewife				10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Washington D.C.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Guy Eversfield Jenkins				14. MOTHER'S MAIDEN NAME: Carrie Christal Clarke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Guy E. Jenkins, brother Washington, D.C.	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
982X Immediate cause (a) RIGHT HEMOTHORAX DUE TO STAR WOUND OF RIGHT CHEST							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO (c) stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Paul F. Merri				CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM. 10-23-55			
23. BURIAL, CREMATION, REMOVAL (Specify): Removal		DATE THEREOF: 10-24-55		NAME OF CEMETERY OR CREMATORY: Glenwood		LOCATION (City, town, or county) (State): Washington D.C.	
DATE REC'D BY LOCAL REG. 10/24/55		REGISTRAR'S SIGNATURE: Paul F. Merri		24. FUNERAL DIRECTOR: C. S. Jones		ADDRESS: Washington D.C.	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 31 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09375

9371

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Crownsville</u>		<u>4yrs.8mos.4days</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1225 E. Monument Street</u> ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u> (Middle) <u>Washington</u> (Last) <u>Washington</u>				(Month) <u>10</u> (Day) <u>24</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Male</u>	<u>Negro</u>	<u>Single</u>	<u>1892</u>	<u>63</u> yrs.	Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Samuel Washington</u>				14. MOTHER'S MAIDEN NAME <u>Della Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
518X IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Empyema right lung</u>						<u>2 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Psychosis with cerebral arteriosclerosis</u>						<u>5 years</u>	
19a. DATE OF OPERATION <u>— — —</u>						19b. MAJOR FINDINGS OF OPERATION <u>— — —</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>— — —</u>						21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>— — —</u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>— — —</u>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. et work) (Not white et work) <u>— — —</u>						21f. HOW DID INJURY OCCUR? <u>— — —</u>	
22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>55</u> , to <u>10/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/24</u> , 19 <u>55</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. Edgar Heard Kern</u> M.D.				DATE SIGNED <u>10/24/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>10/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Latherine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Wilson</u>		ADDRESS <u>1000 Bantley Ave.</u>	
DATE <u>10/31/55</u>							

CERTIFICATE OF DEATH

8271

TO BE FILLED BY THE REGISTRAR OF DEATHS

Name of Deceased Mrs. John A. Smith		Date of Death May 15, 1925	
Place of Birth Baltimore, Md.		Age 62	
Usual Residence 1234 North Ave.		Cause of Death Heart Disease	
Occupation Clerk		Sex Female	
Marital Status Married		Race White	
Date of Death May 15, 1925		Time of Death 10:30 A.M.	
Place of Death Home		Signature of Registrar J. H. Smith	
Signature of Physician Dr. J. H. Smith		Signature of Coroner J. H. Smith	
Signature of Burial Officer J. H. Smith		Signature of Undertaker J. H. Smith	
Signature of Registrar J. H. Smith		Signature of Health Officer J. H. Smith	

REGISTERED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

BUREAU A. 8

RECEIVED

Handwritten signature

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09376

9372

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Kansas</u>		COUNTY <u>Sedwick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort George G. Meade</u>		<u>1 1/2</u> years		TOWN <u>Wichita</u>		<u>54X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 U. S. Army Hospital</u>				<u>2303 S. Emporia</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Della</u>		<u>Elaine</u>		<u>Welsch</u>		<u>October 27 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>October 27, 1955</u>				<u>6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Perry Welsch, Jr.</u>				<u>Helga Gasteiger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mother, 1560 Lambert Road Fort G.G. Meade, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>750X</u> IMMEDIATE CAUSE (A) <u>Anencephaly</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>27 OCT 1955</u> , to <u>27 OCT 1955</u> , that I last saw the deceased alive on <u>27 OCT 1955</u> , and that death occurred at <u>630A</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Leon E. Kassel, MD</u>				ADDRESS (Street, city, town, state) <u>Fort George G. Meade, Md.</u>		DATE SIGNED <u>27 Oct 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>28 Oct 55</u>		<u>Post Cemetery</u>		<u>Fort George G. Meade, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>27 Oct 55</u>		<u>WM. L. SAYLOR, 1/Lt MSC</u>		<u>CHAPLAIN QUIGLEY</u>			

2005312445

100-100

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

1955

Page One, No. 23

At the residence of the deceased

THE DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

BUREAU V. 2

OCT 21 1955

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of Vital Records, State Department of Health, Boston, Massachusetts.
 The date of death should be entered in the space provided for that purpose.
 The cause of death should be entered in the space provided for that purpose.
 The place of death should be entered in the space provided for that purpose.
 The age of the deceased should be entered in the space provided for that purpose.
 The sex of the deceased should be entered in the space provided for that purpose.
 The race of the deceased should be entered in the space provided for that purpose.
 The occupation of the deceased should be entered in the space provided for that purpose.
 The date of birth of the deceased should be entered in the space provided for that purpose.
 The date of death of the deceased should be entered in the space provided for that purpose.
 The place of death of the deceased should be entered in the space provided for that purpose.
 The cause of death of the deceased should be entered in the space provided for that purpose.
 The attending physician or coroner should sign and seal this certificate.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09377

Item 18 Film G188 11-9-55 ams

9326

CERTIFICATE OF DEATH

Reg. Dist. No. 2/

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>A.A.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 157 O'Berry CT</u>				STREET ADDRESS (If rural give location) <u>157 O'Berry Court</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Nancy Wilkerson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10-23 1955</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>12-25-1894</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Jones</u>				14. MOTHER'S MAIDEN NAME <u>Ludia Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Bradley Jones 157 O'Berry Ct.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
434.1 IMMEDIATE CAUSE (A) <u>Heart</u>				<u>Congestive failure</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-27-55</u> , 19 <u>55</u> , to <u>10-23-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-22</u> , 19 <u>55</u> , and that death occurred at <u>3:25</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Allen</u>		M.D. <u>62 Cathedral St</u>		ADDRESS (Street, city, town, state) <u>10-24-75</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-26-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cathary</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. REC'D BY REGISTRAR <u>Oct. 25, 1955</u>		REGISTRAR'S SIGNATURE <u>M. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>Annapolis, Md.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *Robert O'Connell*

2. SEX: *Male*

3. AGE: *45*

4. OCCUPATION: *Electrician*

5. PLACE OF BIRTH: *St. Louis, Mo.*

6. DATE OF BIRTH: *Jan 15, 1900*

7. DATE OF DEATH: *Jan 22, 1945*

8. PLACE OF DEATH: *St. Louis, Mo.*

9. CAUSE OF DEATH: *Myocardial Infarction*

10. MEDICAL HISTORY: *None*

11. SIGNATURE OF PHYSICIAN: *[Signature]*

12. SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. B.

1945

Received 10-20-22
Dr. J. H. [Signature]
Dr. [Signature]

09378

9373

CERTIFICATE OF DEATH

Reg. Dist. No. 27

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1.55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Anne Arundel	MARYLAND	STATE Maryland	COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Crownsville	LENGTH OF STAY (in this place) 5 mos. 10 days	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore City	3Y01-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital		STREET ADDRESS (If rural give location) Not given 1032 N. acquiths	
3. NAME OF DECEASED (First) (Middle) (Last) John Wingate		4. DATE OF DEATH (Month) (Day) (Year) 10 12 19 55	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Unknown
9. AGE last birthday 63 (63) yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unk.	11. BIRTHPLACE (State or foreign country) Derlington S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jerry Wingate	
14. MOTHER'S MAIDEN NAME Salina (Maiden name unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unk. Unk.	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT & ADDRESS Hospital Records	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) Pneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO 086X (B) Cerebral vascular accident (C)			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CNS Lues			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21c. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/2 , 19 55 , to 10/12 , 19 55 , that I last saw the deceased alive on 10/12 , 19 55 , and that death occurred at 1:30 a.m. from the causes and on the date stated above.			
SIGNATURE (L. Benedict, M. D.)		ADDRESS (Street, city, town, state) Crownsville, Md.	
DATE SIGNED 10/12/55			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-16-55	Derlington S.C.	S. Carolina
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
Oct. 20, 1955	Katherine M. Joyce	Chas. O. Wilson	1010 Bantley av

CERTIFICATE OF DEATH

1953

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Cause of death

8. Date of death

9. Place of death

10. Signature of physician

11. Signature of registrar

12. Signature of medical examiner

13. Signature of coroner

14. Signature of health officer

15. Signature of registrar

16. Signature of medical examiner

17. Signature of coroner

18. Signature of health officer

19. Signature of registrar

20. Signature of medical examiner

21. Signature of coroner

22. Signature of health officer

23. Signature of registrar

24. Signature of medical examiner

25. Signature of coroner

26. Signature of health officer

BUREAU N. 2

OCT 21 1955

RECEIVED

RECEIVED
BUREAU OF HEALTH
BALTIMORE, MARYLAND
OCT 21 1955